

**Pre-registration students' experiences of humour use
in the clinical setting within the United Kingdom:
an interpretative phenomenological analysis**

**Thesis submitted in partial fulfilment of the degree of
Doctor of Nursing**

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Abstract

Aim and research question:

The aim of this study was to explore pre-registration students' experiences of the use of humour in the clinical settings in the United Kingdom.

Method:

The chosen methodological approach was interpretative phenomenological analysis (IPA). IPA enabled investigation into the students' experience of humour with patients and mentors and to understand their idiography of their experiences due to different professional journeys.

Ten semi-structured interviews were conducted with nursing students. Each interview was analysed, descriptively, conceptually and linguistically, which is consistent with the IPA approach. Then a cross group analysis elicited common or shared themes within the group.

Findings:

Students acknowledged the individuality of humour and how it reflects their personality and how they can be embroiled in a tug-of-war with the people around them on the use of humour within the clinical setting. Three superordinate themes were identified: 1) the professional journey, 2) the humanity of humour, and 3) humour influences and characteristics which led to the formation of a humour awareness compass for nurses. This study offers a novel insight into pre-registration students' experiences of humour in the clinical setting, within the United Kingdom.

Declaration

This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is being submitted concurrently in candidature for any degree or other award.

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STATEMENT 1

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Prologue: Humour and me – my lived experiences

The aim of this prologue is to assist the reader to understand me (the author), how humour has featured in both my personal and professional life, and the external influences experienced which have affected my use of it. These influences, whether from a religious, cultural or political stance, inform how I see the world, which in turn inform this thesis.

People see me as being reliable, responsible and organised. For me, these traits can make me seem somewhat cold, superficial, and as having no sense of humour, and yet I profess myself to be a kind, jolly soul, enjoying the joys of the world in the company of family, friends and my dogs. Join me on this journey as to how my binary thinking developed and how humour featured throughout my life.

As an adult, I do not recall any episodes of me laughing heartily or being a joker, yet my parents laugh constantly when together and my Mum's witch's cackle can crack a smile on anybody's face. Growing up in Paisley (Scotland) in the 1970s as a Catholic meant I attended a Catholic school and was taught by Catholic teachers. The influence of this environment reflects strongly on the development of my subsequent thought processes. I learnt from a young age to recite the Catechism, of which I can only remember the first few questions and answers:

- Who made me? God made me
- What else did God make? God made all things
- Where is God? He is everywhere.

These questions have greatly influenced my personal belief system. As God made me and everything else, and he is everywhere, this means to me that God's creativity and presence extends to the world's living environment. The underlying Catholic doctrine that remains with me is: there are only two categories in life – right and wrong. This trend of binary thinking has remained omnipresent throughout my nursing career; the patient is either alive or dead, which leaves little room for humour.

Early childhood traumas robbed me of many joys as I began to cocoon myself into a shell so that no one could hurt me as much ever again. This influenced my natural jolliness and thinking for the next 20 years. The combination of trauma and catholic upbringing made me solemn in nature, leading me to take solace in my faith.

Often, I would hear I had no sense of humour. However, for me, it was not that I had no sense of humour, but that my ability to create and appreciate humour was shaped and moderated by my experiences of childhood trauma and the rigid doctrine of the Catholic Church.

In 1982, as a family we emigrated to South Africa (SA). Although my school in Scotland was more regulated than other schools due to the Church's influence, in SA it was more like going back in time. Humour memories from this time are of me often 'not getting it' when classmates said or did something funny. This inability to appreciate humour may make me sound like a bore, especially as it endured into early adulthood, but I am quite a chatty person in trusted company.

Choosing nursing as a career just happened; I realised I could get an education and be paid for it at the same time. It seemed only logical for me to seize the opportunity, especially as I was already volunteering at a retired nurses' care home. My nurse training began in 1986, when I enrolled onto the four-year Diploma in Nursing (General, Psychiatry and Community Health) and Midwifery in SA. My clinical placements were predominantly in white-only hospitals or areas as I trained under the Apartheid policies followed by the South African government in the 1980s.

Due to outstanding essential requirements for completion of the midwifery component of my nurse training, namely being short of four deliveries, the principal of my nursing college arranged for a group of us, under escort, to do a set of night duties in a medium-sized government-funded hospital on the eastern side of Johannesburg, situated in a black township. The Group Areas Acts designated residential areas for different racial groups (for example, Johannesburg for white classified groups and Soweto for everyone else). Therefore, being in a black township, delivering black babies under black midwives' supervision, during a riot, presented a unique opportunity.

The year was 1988; political unrest was the norm in SA. I only saw violence on the TV, whether it be in an American action series or on the news. I was a 19-year-old, white, Scots immigrant, in her third year of nurse training, an apolitical being who just wanted to finish midwifery. My parents moved to SA to give us a better life than 1980s Britain could offer. I found myself unquestioning of the system in which I would become an adult, protected from the implications of the Apartheid system, having expanding life opportunities, and feeling the excitement of my future ahead. Taking very much to heart the teachings of the professional code (namely, to be emotionally detached from the patients), I proceeded to become more solemn, curtailing any remaining natural jolliness. This attitude embodies my professional journey where role models taught us to have a 'stiff upper lip' and how it was unprofessional to show our emotions. Yet, opposite me, on this short placement were black registered midwives whom I have in memory as being welcoming, willing to teach us, and laugh with us at 'nurse' jokes.

The environment in which I found myself was very different to that with which I was familiar. In the white hospital labour ward, staff and equipment were at hand, patients had a named midwife (or student) assisting them and assessing them with a cardiotocography machine every four hours, and there was a ready supply of analgesics. In contrast, in the black hospital labour ward, the early-stage labour women were put onto beds and had to get on with it. This is only one example of service disparities between white and black healthcare provision under an Apartheid government.

Thinking back now after gaining chronological maturity, and perhaps life experience, my experience in a black labour ward highlights several factors influencing my current worldview. To begin, placing white students within a black hospital to achieve their educational outcomes is unethical, as the women in labour were being used; they were not given the choice if they wanted a white student to deliver their baby. No meaningful verbal rapport was built up with these women, due to language or cultural differences; therefore, no informed consent was gained. This contradicts the principles of nursing as espoused within the Florence Nightingale pledge (American Nursing Association 2015), which all South African registered nurses were required to take. Under this oath, I am required not to do anything harmful or detrimental; however, I was training under a system (Apartheid) which separated human beings

according to colour. Consequentially, this caused a segregation of healthcare provision and disparity in the availability of services to various racial groups.

The underpinning governmental philosophy of Apartheid – meaning ‘state of being apart’ – driven by a minority group’s fear and need for survival, established by the National Party in 1948, led to a segregated society. For the black majority racial groups, Apartheid meant: oppression, exposure to violence, lack of opportunity, social inequality, economic inequality, illnesses associated with deprivation, and political turmoil. For the white minority racial groups, it offered education, work and freedom of movement. Apartheid must be seen within a historical context as many antecedents of the National Party elite escaped persecution in various European countries or at the hands of British colonial powers.

This system placed me, a white person, ‘above’ the midwives who were both chronologically and professionally senior to me, and the power of Apartheid society afforded me opportunities and personal freedoms, which far exceeded those afforded to the black registered midwives.

My career trajectory took me towards mainland Europe, where I worked in Germany and Switzerland for a decade. During this time, I have fond memories of dancing people with Parkinson Disease to the shower, joking with the older patients about life in general, and the team camaraderie. My experiences as a nurse in Germany allowed me to find the humanity and humour in the delivery of my care without fear of being reprimanded for being unprofessional because I was laughing with the patients.

My own values base was shaped by having lived in two countries with histories of oppressive regimes based on purist ideologies, South Africa and Germany, one beginning the struggle with its past and one never permitted to forget its past. This strengthened my belief in fairness. Furthermore, the example placed within the context of SA’s history, and my living through the political turmoil and reconciliation of the 1990s, taught me to appreciate the need for completeness of the story. Only by listening to the stories above, could an outsider begin to understand what living in SA was like.

Due to personal and professional reasons, I returned to the UK only to find a similar nursing ethos to that of SA. I had to restrain 'me' within my professional role and felt that if I laughed with the patients I would be 'over-stepping' the boundary.

Going forwards, we are now in the post-Francis nurse education context in which the nursing profession is currently waiting to consult on the Nursing and Midwifery Council's response to the *Shape of Caring* review (2015), which changes how nursing programmes are delivered. Certain things, however, never change. Throughout my career as a registered nurse in several countries, I feel humour has allowed me to connect with patients, colleagues, relatives, students and has become integral to who I am today. This realisation completes my journey: I recognise that using humour makes one approachable and can be used in a professional context. People want the best technical care when they are ill. However, they also want to be treated as a human by a fellow human being, as do student nurses by their role models, whether they be teachers or clinically based registrants. I have found that using humour is a conduit to achieving this.

Throughout this professional doctorate journey and the writing of this prologue, I have been able to look beyond my own set boundaries to think about how I see the world and what is important within it. It also explains why humour is important to me: it is integral to being a human being and it connects people across boundaries.

Chapter 1: Introduction

This thesis explores pre-registration student nurses' experience of humour use within the clinical settings in the United Kingdom. This chapter's intention is to frame the research question within the current professional and public contexts of nursing.

1.1 Setting the scene

Within the last decade and a half, I have worked either as a registered nurse (RN) directly employed by the National Health Service (NHS), or as a nurse educator within pre-registration healthcare programmes funded by the NHS. During this time, there have been numerous scandals specifically focused on the behaviour of nurses. Localised incidents reflected in the Ombudsman Report (Abrahams 2011) signalled a lack of warmth, caring, and nurses' humanness; displayed in their non-empathetic behaviour. These images are reminiscent of bygone days when nurses disconnected from their patients through emotional distancing or became desensitised to their suffering (Melia 1987); this was considered 'professional'.

It is not only these incidents which are disheartening but also the current government austerity measures aimed at the NHS. These often result in situations in which RNs work in extremely stressful conditions due to them being unable to deliver the quality care they want to. Influences include staff shortages, resource shortage and expectations from both the public and the profession. The weight of expectation may impair the RNs' ability to find or use humour in their daily lives at work. However, the focus of this thesis is not on the RNs themselves but on the pre-registration student nurses who are the next generation to come.

Taylor (2016) succinctly noted the contradictory expectations of the public, who see nursing as essentially vocational, and the profession, which has a statutory duty to educate to degree level and above. My experience of public expectation was illustrated in numerous conversations in my daily life when I told people I am a nurse; many seemed to think a certain 'type' of person (caring and kind) is best suited to nursing, reinforcing the vocational model. From my professional perspective, I believe that nurses do need to be educated to a higher standard than me because

modern healthcare is more complex, and there is an ever-increasing responsibility placed on nurses via extended roles. However, my belief in the need for nurses to be taught to degree level does not detract from the notion that a nurse should have the ability to show humanity to those in their care. The following sections map the past and current drivers from public and professional expectations.

1.2 The professional context

Contemporary policy drivers, both professional and governmental, aim to increase public confidence in the NHS and nursing by enhancing the patient experience through the delivery of compassionate care (Nursing and Midwifery Council [NMC] 2008a, 2015, 2017b; Department of Health [DH] 2012a). See, for example: *Compassion in Care* (DH 2012b); the Willis Commission (Willis 2012); *Delivering High Quality Care* (DH 2013); the Francis Report (Francis 2010, 2013); the Keogh Review (Keogh 2013); the Cavendish Review (Cavendish 2013) and *Shape of Caring* (Willis 2015).

The *NHS Constitution* espouses a commitment to care through valuing each person as an individual and responding to his/her needs with kindness and humanity (DH 2012c). However, a commonality amongst these above-mentioned reports is the existence of a non-caring culture within healthcare settings, illustrated by the poor attitude of staff and reflected in patients' fear of nurses' reactions when asking for assistance (Francis 2010) or lack of common courtesy leading to negative patient outcomes (Francis 2010; Keogh 2013). By establishing a link between an unprofessional attitude and poor care delivery, the Francis Report (2010) set out recommendations to ensure potential candidates are screened for professional values such as compassion, integrity and commitment. In April 2015, values-based recruitment (VBR) commenced in the United Kingdom, meaning potential students were to be selected based on their ability to demonstrate the relevant values required by their prospective role (DH 2013). The basis of VBR is the recruitment of students on their individual values and behaviours, aligned to the NHS constitution, in addition to academic ability and skills being considered at the point of selection (Miller and Bird 2014; DH 2015; Power and Clews 2015). Waugh et al. (2014) attempted to establish a values-based person specification of prerequisite attributes for student nurses and midwives, which included cheerfulness incorporating a good

sense of humour. Being able to discern when to use humour appropriately lies within the student's own values base and is in accord with Health Education England's (HEE) (2014) general principles of appropriate behaviour for self and others. Groothuizen et al. (2018) recommended higher education institutions (HEI) do not adopt and follow the VBR requirements blindly. Corner (in Dean 2014) reminded us of organisations' responsibility to engender a culture of caring, therefore allowing students to achieve, maintain and develop their understanding of care.

Current drivers aim to promote individualised humanistic compassionate care through the recruitment of a certain type of nursing student, based on their intrinsic values. Once recruited, nursing students require role models. The NMC's professional code of conduct (2008a, 2015) expressly stated that all registrants must act as professional role models to future generations by sharing their knowledge, developing students' psychomotor skills and embracing professional values such as warmth, sensitivity and compassion. This is to ensure the safe and professional delivery of care. However, a disparity remains between the expected professional behaviours (NMC 2008a, 2015) and nurses' attitudes and behaviours as voiced by patients' narratives in the reports mentioned above. This led to a discussion in the section below on the historical and contemporary public expectations of nurses.

1.3 The public context

Whether depicted as the Dickensian character Sarah Gamp (a 'drunk') or an 'angel', the public image of a nurse is influenced by the media and cultural stereotypes. Bridges (1990) highlighted media images of the nurse as a ministering angel, often seen at the patient's bedside. Such an image is in accord with images of Florence Nightingale during the Crimean war. Contrasting images include the 'battle axe' matron as portrayed by Hattie Jacques in the Carry On films, the 'naughty nurse' as represented by various fancy-dress costumes and, finally, the doctor's handmaiden (Abel-Smith 1960). Conflicting images create inconsistency within the public image of nursing and a lack of consensus about the underpinning principles of nursing and its associated behaviours, values, and relationships (Maben and Griffiths 2008), as well as the knowledge and skills required to be an RN (ten Hoeve et al. 2013).

The stereotype of the nurse as an angel impacts on public confidence, and stems from a time when caring was an informal task, delivered by mothers, women in the community, members of religious orders or those in the workhouse who were able to assist the weaker residents (Abel-Smith 1960; Morris-Thompson et al. 2011). The angel image epitomises the personality traits required to be a nurse: willing, compliant, selfless, caring and dedicated (Bridges 1990). These traits reflect religious orders' altruism, which fuelled their arduous travail (Gordon and Nelson 2005), and remain prominent in nursing today. Secular nursing grew under the auspices of Florence Nightingale and Mrs Bedford-Fenwick, and did so within a changing job-market due to the industrial revolution (Gordon and Nelson 2005). Nursing needed to attract potential candidates whose qualities gained them access to a respectable job outside of the home (Gordon and Nelson 2005). For this, nurse recruiters appealed to Victorian values such as charity, piety and respectability. Arguably, these ideals continue today.

Morris-Thompson et al. (2011) identified how the image of nursing held by the public may be in variance with that held by nurses: the public prize nurses for their virtues rather than their knowledge (ten Hoeve et al. 2013). Recognised professional leaders Maben and Griffiths (2008, p. 4) called for "a reinvigorated sense of service" which would allow public confidence in nursing to be restored by delivering what the public want: "empathy; compassion; keeping them informed; doing the right thing at the right time and being with and available to the public". Therefore, if recognised professional leaders reinforce the angel stereotype, and associated traits based on the vocational historical roots, then it will remain a benchmark against which nurses will be measured by the public whose understanding of nurses' professionalism is that it is espoused in their behaviour, communication and appearance (Maben and Griffiths 2008).

Reports such as the Ombudsman Report (Abrahams 2011); the Mid-Staffordshire scandal (Francis 2010); Winterbourne (British Broadcasting Corporation [BBC] 2011); Orchid View (Milmo 2013; Georgiou 2014) and Glan Clwyd Hospital (Walters 2014) continue to shake public confidence, highlighting nurses' failure to deliver essential care in a manner expected of them. In order to respond to these concerns, various organisations, such as HEE acting on the Francis Report recommendations, aim to recruit candidates who demonstrate the values identified above.

1.4 Humour

Humour, as a phenomenon, has interested philosophers through the ages and been researched in many disciplines. Friend (2002) described how humour is difficult to explain, and that it is considered to be a human activity. Acknowledging the sociability of humans, Provine (2000) discovered people were more likely to laugh when together than when pursuing lone activities and categorised laughter as a social vocalisation that binds people together. Martin (1998) contended all humour elements (cognitive, emotional and expressive) have a social dimension and form an important part in interpersonal relationships. Whether humour is the ability to play on words, a reliance on imagination, an intellectual activity, manifested as laughter, being funny, watching comedy or being witty (Martin 2001; Carrell 2008), it remains a universal phenomenon bearing on all human life aspects, for example relationships and interactions (Carrell 2008).

1.5 The research problem

Policy and public drivers focus on recruiting a certain type of person displaying relevant values to enter any pre-registration healthcare programme. Pre-registration nursing students, like many others, claim to have a sense of humour, yet Astedt-Kurki and Liukkonen (1994) highlighted one student nurse's perception that she was not allowed to have a personality, let alone a sense of humour. Therefore, the question arises as to what happens to a student and their pre-existing humour capacity as they progress through a professional programme.

Humour research has been primarily conducted in psychology laboratories with healthy psychology students (McCreaddie 2008b), and within healthcare it predominantly focuses either on the patient's perspective (Robinson 1977; Pasquali 1995; Winter 2006) or the RN's perspective (Sumners 1990). Therefore, the focus of this study is on humour within the pre-registration student nurse population, and to address the paucity of humour research from students' perspective.

As nurse training within the UK context is equally divided between the university and clinical placements (NMC 2010), the focus of this thesis is on the clinical setting since this is the students' future workplace and, anecdotally, they place more value

on this setting. It is within this setting that they learn to interact with others in a professional manner from role models they encounter.

1.6 The research question

The overarching research question of this study is: how do pre-registration nursing students experience the use of humour in the clinical setting within the United Kingdom?

This question concerns the students' experiences of humour within the clinical setting, yet it is crucial to acknowledge that each one's educational journey is different due to the nature of their placements. For example, it is only Adult field students who are currently required to meet the European directives (NMC 2010). Understanding how their humour is utilised when interacting with others on their educational journey will allow the students to make sense of their relational experiences with others, within the clinical setting.

Initially, I intended to utilise a mixed methods approach. That is, the first part of the study was to involve employing a questionnaire to plot the participants' humour style and, because of the vast array of literature emphasising the influence of demographics (such as gender, age, and ethnicity) on the use of humour in daily interactions, to ascertain whether these influences were quantifiable. The second part was to make use of an interpretative approach, exploring participants' experience of humour use within the clinical setting by utilising a phenomenological approach aimed at uncovering the meanings of the lived experience of humour for the individual. However, only the qualitative phase (aimed at investigating and understanding participants' experiences of humour use in UK clinical settings) produced rich enough data to be explored and, therefore, only it remained the focus of this thesis.

1.7 Phenomenological considerations

Phenomenologists offer variation in their interpretation of phenomenology since it can be a research methodology or a philosophical approach (Moran 2000). The underpinning principles connecting all phenomenological interpretations are the twin desires to understand human experience and to investigate such experiences

(Langdridge 2007). Willig (2001) complemented this by adding that phenomenology is how humans gain knowledge of the world around them.

The phenomenological approach that this study adopts is interpretative phenomenological analysis (IPA). IPA concerns itself with people as interpreters of the world around them. Smith and Eatough (2012, p. 441) explained that the aim of IPA is to explore “the meanings particular experiences, states, events and objects have for people”.

In order to achieve this, IPA combines descriptive and interpretive strands of phenomenology (Smith et al. 2009), which are illustrated in chapter four. This study is interested in capturing pre-registration students’ lived experiences of humour in the clinical setting as this is their future workplace.

This thesis is divided into eight chapters. The first four chapters detail the background of the thesis, with a particular focus on humour and its development. The remaining chapters are dedicated to the execution of the research design, findings and conclusion.

Chapter 2: Capturing the essence of humour

Much of this chapter creates a backdrop for capturing the essence of humour and how this contributes to the definition of humour adopted for this study. This chapter's aim is not to provide a detailed overview of the humour field but to offer the reader an understanding of the field and its influences pertinent to this study's research question. Additionally, it outlines the relevance of humour to and for student nurses. A comprehensive narrative literature review is offered in chapter three.

This thesis is concerned with student nurses' experience of humour use within the UK clinical setting and it is here that they engage in social interactions with service users, members of the public and their professional peers. The first section of the current chapter summarises the theories of humour, providing an overview of the historical development of humour and laughter. The discussion continues with the conversational spontaneity of humour. Then the focus moves to rehearsed humour, with an extended emphasis on the clinical setting. Subsequently, humour and its function in social interactions are explored in relation to both group relationships and the individual lenses affecting one's use of humour and one's identity. Developing an understanding of this interaction of humour in social settings, and the variety of individuals' experience and use of humour, is extremely pertinent to the maturing of a student nurse. The final sections summarise the types and additional functions of humour to aid further discussions within forthcoming chapters.

2.1 Humour: meaning and the theories

Various philosophers have endeavoured to portray a universal theory of humour but several theories remain. Firstly, the word 'humour', influenced by the historical and social contexts, developed from originally meaning bodily fluids to becoming an umbrella term. Alongside the ever-changing meaning of 'humour', the development of the three main humour theories occurred: superiority, incongruity and release. These three are discussed alongside linguistic theories of humour, which are considered a sub-section of the incongruity theory as both rely on cognitive abilities.

Figure 2.1 charts the meaning given to laughter and humour across the centuries and plots concurrent theory developments.

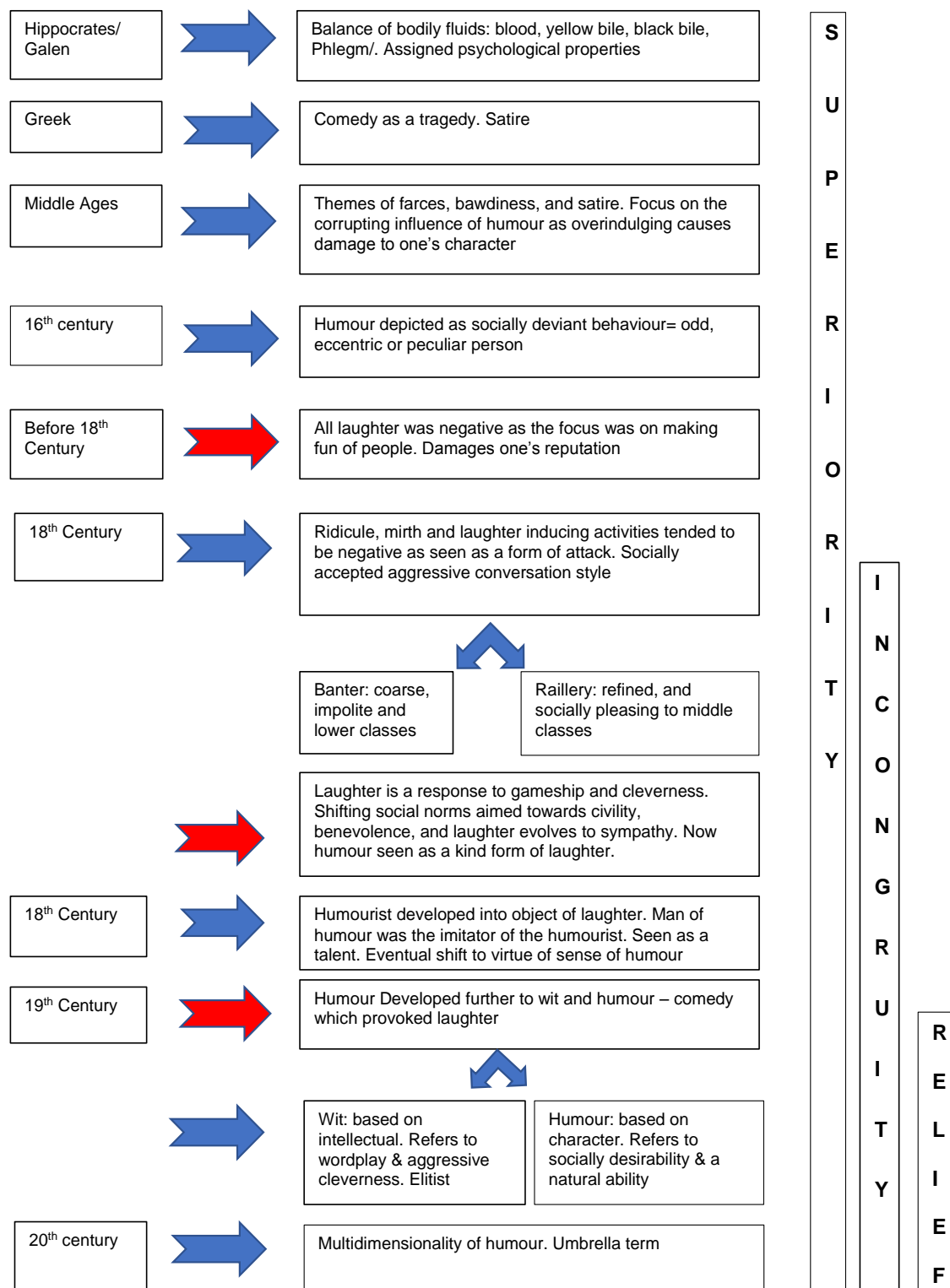


Figure 2.1: Humour and laughter development across the ages (blue is humour, red is laughter) (Lippitt 1995b, Ruch 1998, Flaskerud 2012, Morreall 2012, Nilsen and Nilsen 2016)

Table 2.1 presents an overview of the predominately featured theories within the literature. Each theory is presented with its component parts: proponent, key elements, function and form. A brief critique of each theory and an example now follows.

Table 2.1: An overview of humour theories

Theory	Proponent	Key elements	Function	Form
Superiority (Social)	Socrates ("pain of the soul") Plato Aristotle Hobbes ("vainglory") Bergson Gruner	Feel superior (amused at others expense or younger self)	Mockery Derision Social corrective	Ridicule
Release/relief (Emotional)	Spencer (physical) Freud (psychic)	Release of built up tension Taboo subjects	Defence or coping mechanism	Gallows humour Slapstick humour
Cognitive (Understanding)	Kant Schopenhauer Hazlitt Kierkegaard Suls	Sudden or unexpected bringing together of two disparate ideas or events or situations, thus producing an absurdity	Mockery Defence or coping mechanism Adult form of play	Jab line / Punchline
Linguistic	Graham Norricks Attardo Raskin	Humour being communicated through language	Social probing	Witticism Joke definition

(Keith-Spiegel 1972; Suls 1977; Morreall 1983; Norrick 1984; Berger 1987; Monro 1988; Lippitt 1994, 1995a, 1995b; Gruner 1997; Martin 1998; Ewin 2001; Bardon 2005; Lippitt 2005; McCreaddie and Wiggins 2008; Smuts 2010; Earleywine 2011; Warburton 2011; McDonald 2012; Perks 2012)

The superiority theory dominated until the eighteenth century (see Figure 2.1). To this point, the focus was on laughter; as Morreall (1989) indicated, the earlier versions of this theory do not distinguish humour, laughter or comedy from each other. Within writings supporting the notion of humour as superiority, it is commonly acknowledged that the person laughing feels the superiority, as seen in ethnic-based jokes (Critchley 2002) or incidences of *Schadenfreude* (Cohen 2001). Cohen (2001) contentiously posited that both oppressor and oppressed can benefit from feelings of superiority. For example, concentration camp inmates joked about their Nazi captors

(Frankl 1992). A modern-day example would be Donald Trump's mimicry of a disabled reporter (Cable News Network [CNN] 2015).

An underpinning assumption of this theory is that humour and laughter involve the loss of self-control or the breaking of social rules (Morreall 2009), thereby placing humour in a negative light. Arguably, however, these feelings of superiority can alleviate stress and allow people to maintain self-esteem and sanity in times of adversity (Martin 2009). The overarching themes remain aggression and malice-provoking emotive responses (Carrell 2008), as depicted in Morreall's (1983) example of Victorians' amusement at the taunting of asylum residents.

Critics of the superiority theory highlight the narrowness of its focus: not all humorous situations evoke feelings of superiority, nor is humour found in all situations where superiority feelings arise (Cohen 2001).

Moving onto the relief/release theory, Martin (1998) detailed Freud's three types of mirthful experiences: jokes, the comic and humour. Freud posited that superfluous psychic energy from each experience will be released as laughter (Morreall 1983).

Many authors (Monro 1988; Martin 1998; Smuts 2009; McDonald 2012) emphasised Freud's joke element, since this allows people to laugh at subjects deemed taboo by psychological or societal restraints (Cohen 2001; Freud 2001). There are two types of joke: innocent and tendentious (Lippitt 1995b; Freud 2001). Tendentious jokes allow the expression of unconscious impulses, whether sexual or hostile (Kline 1977; Martin 1998; Ferguson and Ford 2008), whilst concealing its purpose. Freud's second type, the comic, presents predominantly non-verbal or slapstick humour, so when expectations are not met, cerebral energy is released and laughter ensues (Martin 1998; Smuts 2009). Finally, according to Freud (1928), the adoption of a humorous attitude protects against possible suffering. This allows one to avoid the negative emotions of a stressful situation due to amusement arising from incongruities within the situation (Martin 1998). An example here is health professionals laughing at inappropriate times, such as the death of a patient. Billig (2005) explained that this off-setting of suffering can be linked to cognitive reframing.

Critics have highlighted the improbabilities of Freud's relief theory: he did not differentiate his psychic energy from other body energy sources (Morreall 1983;

Lippitt 1995a), nor account for the storage of the psychic energy (Smuts 2009). Additionally, humorous laughter is generally indistinguishable from non-humorous (Cohen 2001; Smuts 2009). The critique has also focused on Freud's ignoring of the individuality of sense of humour (Lippitt 1995b).

Moving onto incongruity theory – this is considered to be the cognitive theory of humour, or the theory of understanding (Banas et al. 2011). Specifically, the basis of the incongruity lies within the cognitive rather than in the social or emotional aspects of humour (Martin 1998, 2007; Krikmann 2006). This relies on the sudden or unexpected bringing together of two disparate ideas, events or situations, thus producing an absurdity that results in laughter (Robinson 1977; Berger 1987; Martin 1998). Alternatively, Shaw (2010, p. 115) claimed “humour involves delighting in a departure from some regularity or norm”. Martin (2007) explained that different brain regions are involved in the cognitive processing of humour types, for example Broca's area for resolution of the incongruity. Examples include a joke and its punchline (Ritchie 2004) or the anthropomorphic image of talking animals dressed like humans (as in Gary Larson's 'Far Side' cartoons).

Martin (1998, 2007) highlighted that many authors reject the idea of the incongruity being funny, instead seeing the resolution offered as producing the amusement (Rothbart and Pien 1976; Jones 2006; Zhan 2012). This means providing further information allows the incongruity to be resolved (Ritchie 2004), which relies on another part of the brain to solve. Examples include 'knock-knock' jokes and captioned cartoons.

Critics of this theory have claimed that the concept of 'incongruity' is too broad in scope to be a central feature applicable to all humour (Monro 1988; Smuts 2009), especially seen in examples of incongruous situations which are unfunny, such as laughing in victory, in sympathy, or at snow in summer (Clark 1987; Cohen 2001; Bardon 2005).

Within cognitive theory, linguistic theories have emerged, defined as humour communicated through language (Martin 2007). Of the several categories within linguistic theory, the main areas of importance are pragmatics (rules for the interpretation of language in context and appropriate social use) and semantics (the meaning of words) (Martin 2007). This theory relies on the recipients' cognitive ability

to either process verbal content, leading to its appreciation, or react to verbal stimuli. Criticism of this theory lies within the narrowness of its scope since it applies only to verbal humour and lacks attention to the other aspects of the given context.

Lynch (2002) maintained that all of the above theories were developed in the historical times of their creators and the linguistics of the time, and relate primarily to the individual's motivation and interpretation of humour. Morreall (2009) reminded us that humour is a complex phenomenon and each theory is insufficient on its own; therefore, no one theory can be subscribed to. In conclusion, exclusivity and subjectivity for the most part render giving a single definition to humour impossible in spite of the myriad of theories offered from the Ancient Greek to the contemporary philosopher.

Placing humour development within its historical context begins to build a basis of understanding which helps answer this study's research question about student nurses' experiences of humour use within the clinical setting. This represents the ever evolving definition of humour based on changing societal influences. As the variety of humour theories have demonstrated, humour cannot be reduced to one entity. Being identified as a complex phenomenon, there is a need to examine other contributions to the humour field. This represents the multi-dimensionality of humour which in turn can impact on the students' experiences at an individual, organisational or societal level. Because of the limited confines of this thesis, these are presented below in diagrammatic format (Figure 2.2). The concepts within this diagram are discussed in later chapters in order to explore the student nurses' understanding of humour and how it potentially impacts on their work.

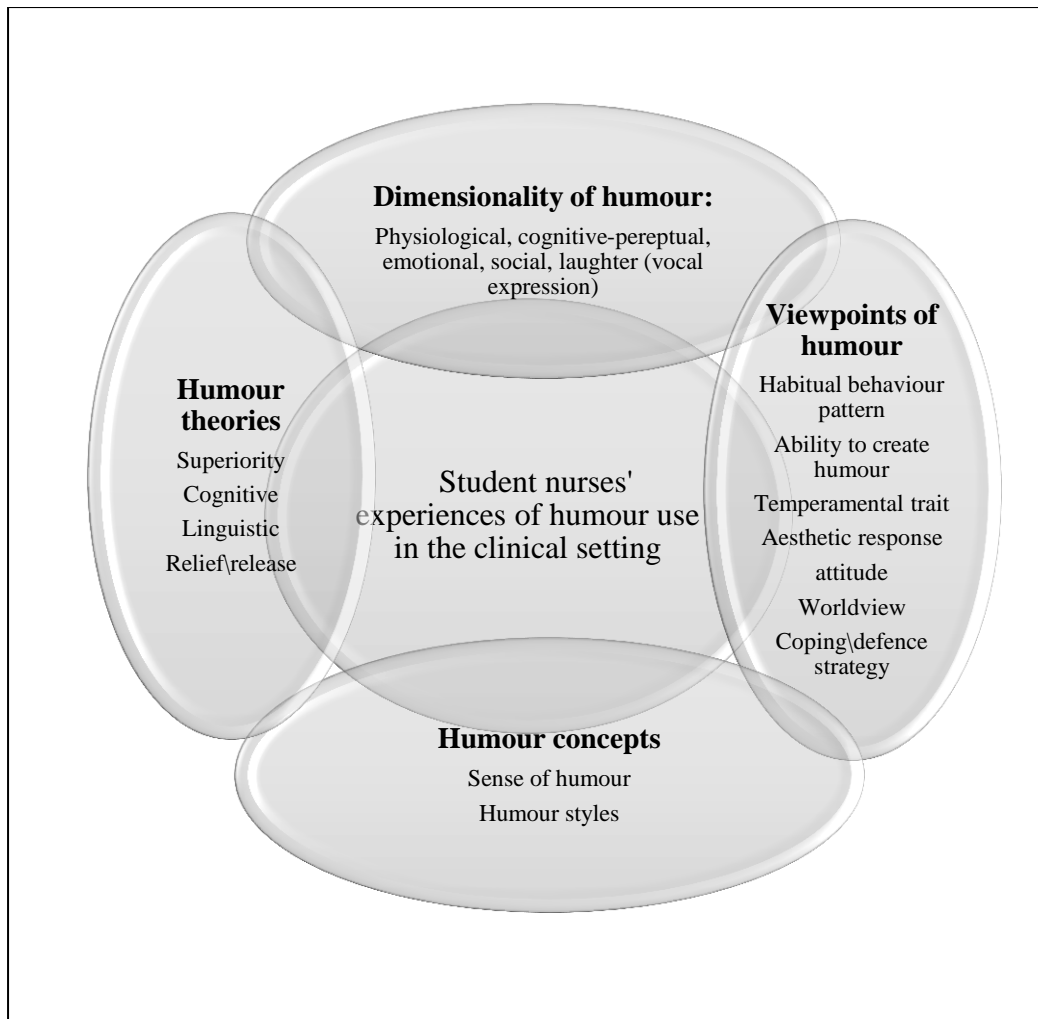


Figure 2.2: The multi-dimensionality of humour (Martin 2007, Ruch 2007, Melton 2016, Scheel 2017)

The preceding sections have demonstrated the multi-faceted nature of humour and offered an understanding of humour in the wider context; however, this thesis is concerned with student nurses and humour use within in the clinical setting. Therefore, the focus is on aspects of humour within the healthcare literature. The following section concentrates on humour as a conversation; humour as performance; the social lubricity and abrasiveness of humour, and finally humour as identity.

2.2 Humour as conversation

The ambiguity of spontaneous conversational humour is detailed here and its application to individual and healthcare contexts is illustrated. Further points for consideration are laughter and its complexities, and self-deprecating humour (SDH).

Many authors have recognised spontaneous humorous occurrences in the majority of everyday interactions and within various social contexts (Martin 2007; Graham 2010). Wyer and Collins (1992, p. 663) noted:

it is a rare conversation in which at least one participant does not respond with amusement to something said or done. Jokes, witticisms and other humorous verbal and nonverbal behaviours are commonplace in social interactions and can have a major impact on the quality of interactions.

Martin (2007) divided the spontaneity of humour into three areas: 1) rehearsed jokes and cartoons, 2) intentional humour (verbal or non-verbal) created within a naturally occurring conversation and 3) unintentional humour (physical or linguistic).

In naturally occurring interactions, normally two or more people are involved. Within this context, Hay (2001) explained, the audience has to recognise the humorous attempt, understand it, appreciate it and then decide if they agree with the conveyed message. In Ritchie and Negrea-Busuioc's (2014) study of informal conversations about public safety and police-community relations with regards to metaphor and story-telling, the authors concluded initial conversational intentions can change through conversational dynamics and the spontaneity of humour occurring in the moment.

There is often a focus on the linguistic aspects of humour, yet Heath and Blonder's study (2005) noted that, for stroke survivors, it is important to be able to recognise facial expressions and vocal patterns used to stress or intone patterns of language in order to decipher whether humour is appropriate or not. Additionally, Flanson et al. (2011) highlighted the importance of vocal signals in recognising humorous occurrences. Whilst from their own ethnographic study of a Brazilian collective farm they could not prove how a speaker signals humour production for audience understanding, they did note how certain segments, namely set-up and punch line, were louder than usual speech. Arguably, the above suggests it is not only the words used but also the use of one's body in humour delivery which is important in spontaneous humour.

Across Hay's work (1995; 2001; 2002) concerning 16 friends' spontaneous conversations, based on literature and her findings, she developed a framework to

illustrate how humour function contributes in different ways to an interaction. See Table 2.2 below.

Table 2.2: Hay's humour functions

Solidarity	Power	Psychological
Share Highlight/capitalise on shared experience Boundary Solidarity Tease Solidarity Other	Foster conflict Control Boundary Power Tease Power	Defend/protect oneself (identify a weakness before someone else does) Cope (putting self-down/ making light of serious situation) General Situational

Hay (1995; 2000)

Interactions with people are a core element of any health practitioner's day, with spontaneous humorous interchanges a frequent occurrence and often being lauded for their positivity. McCreddie and Payne (2011) called attention to the challenges of researching spontaneous humour in this area, especially due to the dearth of focus on nurse–patient interactions. In Beck's (1997) study of 21 postgraduate nurses, the participants' narratives demonstrated their use of humour as being both unexpected/spontaneous and planned/routine. Spontaneous humour was mostly employed, which supports Astedt-Kurki and Liukkonen's (1994) conclusion that nurses use humour intuitively. Yet Robinson (1977) considered that for humour to become a spontaneous communication pattern, it must be consciously and deliberately exercised, often over-exaggerated and over-practised. McCreddie (2010) discussed an example of deliberate yet spontaneous use of humour with a service user. She termed a phrase "harsh humour" (p. 633), which from an outsider perspective may be classed as being offensive or unprofessional; however, McCreddie elaborated that this type of humour "used areas of potential discord for humour creation and maintenance" (p. 633). Within the mentioned example, a disenfranchised service user (with a history of clinic non-attendance) was drawn in by the clinical nurse specialist's (CNS) deliberate use of harsh humour. This was contrary to McCreddie's (2008b) earlier main findings. McCreddie and Payne (2011) noted that CNSs are less likely to use humour deliberately due to their lack of risk-taking. This suggests that nurses need to recognise the spontaneity of humour in interactions with colleagues and patients. Nurses are not the only occupational

group that use humour deliberately or spontaneously in the workplace with clients or colleagues, either in institutional or non-institutional workplaces (Taylor and Bain 2003). This is discussed further in section 2.5.4.

Often there is an assumption that laughter will be present when something is amusing; however, Hay (2001) maintained that limiting studies of laughter to its close association with humour is to deny its complexity. The complexity of laughter has been evidenced in various disciplines researching its different aspects; for example, Martin (2007) described the biological processes (psychobiology including phonology) of laughter and its association with humour; Scott (2015) detailed the neuroscientific functions of laughter; and Hay maintained it is one of many support strategies of humour within interactions.

Scott (2015) described how laughter can be divided into two forms: involuntary and voluntary. She explained that the involuntary form of laughter stems from mammals (humans, primates and rats) and is an indicator of playfulness and tickling. Her attention to voluntary laughter dealt with the meaningfulness of why people laugh within interactions, which is linked to the social aspects of laughter. For Glenn (2003) and Hay (2001), the social and communicative aspects of laughter were of interest, especially those occurring in natural conversations.

Glenn (2003) asserted that laughter has a chameleonic nature influenced by internal and external factors and has a duality in its uses. Just as Martin (2007) associated laughter with positivity, Glenn pointed out laughter can be connected with aggression, dominance and hostility. Both Scott (2015) and Glenn explained that laughter and its execution is affected by the presence of others, their laughing status, and the relationship one has with them; it can show love, like or hostility. They also asserted that laughter can demonstrate one's position within a group since it can simultaneously display disaffiliative and affiliative properties. Therefore, one can laugh at and with people at the same time. Glenn and Holt (2015) maintained that laughter is instrumental in the creation, development and maintenance of one's role (Glenn 2010), identity (Rees and Monrouxe 2010) and relationships. Furthermore, in Rees and Monrouxe's (2010) study of laughter and learning at the patient's bedside, focusing on disaffiliative laughter, they evidenced the duality of laughter through both the maintenance and challenging of power imbalances.

From the audience's perspective, laughter and other strategies for humour support are areas Hay (2001) investigated, based on spontaneous humour within an informal group. She noted the overwhelming assumption that an audience's laughter is the usual and most suitable way to react to any attempt at humour. However, she presented other strategies for humour support, including contributing more humour, playing along with the gag, using echo or overlap, offering sympathy and the audience's non-agreement with one's use of SDH.

Within the literature, SDH has commanded much attention in both negative and positive frames; therefore, this type of humour needs to be explored in greater detail. SDH as a type of humour lies within the disparagement/superiority humour field. Ferguson and Ford (2008, p. 283) described disparagement humour as referring "to remarks that (are intended to) elicit amusement, through the denigration, derogation or belittlement of a given target (individuals, social groups, political ideologies, material possessions)". An example of this type of humour is ridicule targeted at certain group members or groups (Janes and Olson 2010). Additionally McCreddie and Wiggins (2009) highlighted that certain problematics lie within the use of disparagement/superiority humour. Martin (1998) explained that self-disparagement comes from the feelings of superiority experienced over one's past foolishness or 'gaffes'. Janes and Olson (2010) indicated that the lines between self-enhancement and self-disparagement are blurred. Craik and Ware (1998) described a continuum of disparagement between being reflective and being boorish that is "a knack for discerning the spontaneous humor found in the doings of oneself and other persons and in everyday occurrences, at the positive pole, and an uninsightful, insensitive and competitive use of humor, at the negative pole" (p. 75), respectively. In their study, these styles of humour conduct were determined when using the Humorous Behavior Q-sort Deck (HBQD), and the intention of the HBQD was to offer a complete picture of everyday humorous conduct. Martin (2007) highlighted the limitations of using the HBQD.

Within the disparagement humour literature, there is a need to clarify terminology based on the level of deprecation and the harm intended (Janes and Olson 2015). Lee et al. (2015, p. 1186) outlined self-*deprecating* humour as "comments used in an affiliate manner which invite the audience to share in the laughter at their self-targeted foibles". Whereas Martin (2007, p. 211) stated that self-*defeating* humour

involves the excessive use of self-disparaging humour attempting to amuse others by doing or saying funny things at one's own expense and laughing along with others when being ridiculed or disparaged. It involves use of humour as a form of defensive denial or avoid dealing constructively with problems.

It seems that the intensity of the self-deprecation can be placed along a continuum which in turn determines the term used to describe it. For the purpose of this section, the term 'self-deprecating humour' (SDH) is used.

Gkorezis and Bellou (2015) explained that, by using SDH, an individual either signals a willingness not to take oneself seriously or highlights his/her own weakness before someone else does. Furthermore, they suggested that this stance allows one to appear carefree or to give an impression of humility by making oneself vulnerable. Leaders are known to adopt this type of humour as a means of diminishing the power differential; it achieves their goals (Janes and Olson 2015) and may lead to others perceiving them as being more effective (Gkorezis and Bellou 2015). Janes and Olson (2010) maintained that using SDH has a non-inhibitive effect, thereby growing one's potential for creativity and openness to newer and bolder ideas. The risk of using SDH is that others may not take one seriously or the intent behind its usage is clouded.

Across the humour literature, there seems to be consensus that women use SDH to promote intimacy since sharing one's own foibles enables one to encourage laughing with, rather than at (Kotthoff 2006). However, Hay's (2002) findings suggested that it is problematic to attempt to categorise SDH as being predominantly a function of women's humour because men's use of this humour increases in mixed-sex company.

It can be suggested that the problem of using SDH is not limited to gender. Within a nursing context, McCreaddie (2008b; McCreaddie and Payne 2010) highlighted the potential for SDH to be problematic depending on the intent behind its use and that the recognition of the intent is pivotal to addressing patients' needs. McCreaddie and Wiggins (2009) continued that within care interactions, patients seek to balance these interactions by adopting a "good patient persona" (p. 1084), characterised by compliance and "sycophancy" (over gratitude) (p. 1085); therefore, through their use of SDH, they can either challenge/criticise their care or voice concerns. A problem

with patients using SDH is that a healthcare professional may not recognise this type of humour and/or the intention underpinning its use, or may accept it superficially, leading to a decision that no action is necessary (Du Pre and Beck 1997; Berger et al. 2004). McCreaddie and Wiggins illustrated that SDH may be recognised as problematic if used by a patient excessively within a shortened timeframe, in isolation from the topic or coupled with gallows humour.

Using SDH is not limited to the individual. Lee et al. (2015) discussed the effectivity of a health promotion campaign on binge drinking by comparing the use of self- and others-deprecating humour and non-humorous interventions in health promotion messages. In their study, it was thought that using SDH would reduce the binge-drinking behaviour as the disparager belonged to the targeted group and did not directly criticise the behaviour. This was supported by Ellithorpe et al.'s (2014) suggestion that the perception of humorousness is measured differently by an audience when the source of the humour (initiator) is a member of the targeted group (butt). However, Lee et al. concluded that others-deprecating humour appears to have had the greater effect on reducing the binge-drinking behaviour. Furthermore, they also concluded it was the personal investment which one has in the behaviour that ultimately influences the lasting health effect, rather than the type of humour used within the health promotion message.

2.3 Humour as 'performance'

The following discussion concentrates on rehearsed humour interventions within healthcare settings, namely paediatric and older people's services. It examines the role of elder clowns in the older person's experiences and the effectiveness of a clowning workshop for student nurses.

The prevalence and dominance of quantitative studies designed around humour as a positive phenomenon has been well-documented (Martin 2007, McCreaddie 2008b). Such studies rely on using rehearsed humour interventions such as jokes or cartoons with young healthy adults, often in a context-free environment (McCreaddie and Payne 2011). For McCreaddie (2008b), this highlighted the limitations of correlational studies as they represent the viewpoint that humour, to a certain extent,

is a stable trait of personality, yet people experience humour differently (Foot and McCreaddie 2006; McCreaddie and Wiggins 2009).

Studies using rehearsed humour interventions (applied humour) within nursing practice focused on humour as a therapeutic intervention, which has a positive outcome (Wooten 1996a, Shields 2014). This has been termed therapeutic humour.

The Association for Applied and Therapeutic Humor's (AATH) academy membership crosses many disciplines and presented a definition of therapeutic humour as being

any intervention that promotes health and wellness by stimulating a playful discovery, expression or appreciation of the absurdity or incongruity of life's situations. This intervention may enhance health or be used as a complementary treatment of illness to facilitate healing or coping, whether physical, emotional, cognitive, social or spiritual (AATH 2000).

In order to achieve this, Wooten (1996a) advocated humour rooms, comedy carts, humour baskets and caring clowns, such as Nurse Kindheart. It can be said nurse clowns are an extension of medical clowns, as depicted by Patch Adams. This type of clowning is known by many names: humour therapy, therapeutic clowns, clown-doctor, medical clown, hospital clown, or elder clown – this is dependent on whether the clown is healthcare personnel or a professional performer (Warren and Spitzer 2011). One's original profession would dictate the type of clown training required; for example, healthcare staff can undertake a humour course in institutions such as the Big Apple Circus in the USA (Duffin 2009) or become a "laughter boss" in Australia (The Humor Foundation 2017). Whereas professional artists, especially those working in Older People's services, recruited for their personal attributes, receive additional training in conditions such as dementia (Warren and Spitzer 2011).

Rämngård et al. (2016) clarified the significance of a clown's ability to use their body, emotion and cultural awareness within interactions. Duffin (2009) drew a parallel between clowns and nurses: being able to know or understand your audience results in a less mechanical performance. For Linge (2011), this created an atmosphere of ease and cheerfulness. Duffin explained that a clown monitors the climate of the audience and alters their behaviour to engage it as needed; for example, they offer an audience member the chance to participate in the show. This suggested that nurses could potentially learn to read the emotional climate of their surroundings and

have a heightened sense of the people within it, a dynamic which Linge highlighted could increase staff competence.

Clowns within Paediatrics services are well documented. Finlay et al. (2016) reviewed the main effects that clowning has within this setting: it enables the children to deal with various practical procedures or medical conditions, it gives them control over their interactions and it assists the children's interpretation of, and adaption into, this strange environment.

Throughout Linge's work (2011; 2012; 2013) within the Swedish paediatric setting over a seven-year period, she interviewed clowns, healthcare staff, children and parents. In her 2013 meta-analysis of 51 interviews, she presented results based on the quality of care. She noted the clown focuses on the healthy part of the child with the intention for the child to express their wishes. She felt this presented a "magical safe area" where external demands and adjustments were laid to one side; therefore, there was "joy without demands" (Linge 2011, p. 1).

A reflection of this "joy without demands" within a "magical safe area" in the adult care setting is the separately developed elder clowns programme. Warren and Spitzer (2011) described elder clowns as being professional artists who work with older people living in various formal community healthcare settings (residential or nursing care homes), using such strategies as story-telling or jokes, music therapy or singing, and improvisation from the material background.

Symons' (2012) multinational study of elder clowns concluded that this role is important for people suffering from dementia, both psychologically and socially, as it supported their interactions. He concluded that a well-trained clown did not infantilise the residents, rather affirmed, delighted and empowered them. This conclusion has been supported by current studies such as Kontos et al. (2015) and Rämngård et al. (2016).

Kontos et al.'s (2015) Canadian ethnographic study of a twelve-week elder clown programme involved 23 residents with varying degrees of dementia, living within a care facility. The elder clowns received additional dementia training before the residents were exposed twice weekly to ten-minute visits from a clown duet. As each resident's information was shared with the clowns, they were free to use any artistic

strategy such as dance or music best suited to the resident's current mood, communication style or condition. Kontos et al. concluded "relational presence" (p. 46) demonstrated the residents' intentional ability to respond in a playful and funny manner, and that their use of imagination was often overlooked by care staff.

Another ethnographic study, from Sweden by Rämngård et al. (2016), focused on the cultural aspects of elder clown–resident interactions, choosing two homes: one in an urban setting with predominantly foreign-born residents and the other in a rural setting with mainly Swedish-born residents. Over ten weeks, the residents, with varying degrees of mobility, received clown sessions lasting three to four hours across both individual and communal spaces. Nursing staff did not engage in the clown sessions. Unlike Warren and Spitzer's suggestion (2011) that elder clowns performing in formal healthcare settings (now people's homes) should use a softer approach by not adopting the typical clown costume (garish make-up, floppy shoes and over-sized clothes), these elder clowns, who were professional artists, wore typical clown costumes and, similar to Kontos et al. (2015), received additional training on dementia and demographic information of the residents.

Rämngård et al. (2016) concluded that the clowns supported social interaction by being attentive in a culturally appropriate way; they used sensory triggers to encourage and affirm the residents' sense of identity, for example using a scarf and belly-dancing moves for a resident who originated from the Middle East. Such interventions may be deemed culturally inappropriate within a British care setting (discussed in section 7.3.2). However, within the communal areas, a sense of togetherness was established.

From both Kontos et al. (2015) and Rämngård et al. (2016) the recommendation for healthcare teams is the need to reconsider the relationship with residents and embrace new ways of improving communication in a non-demanding way. This has been supported by the findings of a multi-site evaluation in Sydney of professional elder clowns and laughter bosses (Humour Foundation 2017), commissioned by the Humour Foundation in Australia: this concluded staff morale improved and the facility's positive atmosphere increased due to the use of these roles. In addition, the staff felt less stressed and attitudes towards care became more positive as empathy and relationships improved.

Across the clown programmes there is a consensus that clowning supports interaction within the various client groups (across a variety of settings) by offering them control and the ability to enjoy the clown without any demands being placed on them. Clowning focuses on the individual and not the illness/condition. It also gives the possibility to improve relationships between caregiver and patient as it enhances the emotional climate of the facilities, and potentially enables the staff to understand their clientele better, which in turn may increase their work-satisfaction levels. However, scepticism about the benefits of such programmes remains, based on a dearth of research and individuals' differing perspective on/definition of professionalism (Duffin 2009).

More recently, from an educational perspective, Leef and Hallas' (2013) study on the long-term effectiveness of a Sensitivity Training Clown Workshop was aimed at 131 baccalaureate nursing students' understanding of emotions, learning of peripheral awareness and their patient engagement (within a paediatric setting). Using a longitudinal design, 18 months after the workshop they concluded from a follow-up questionnaire (n=40) that 80 per cent of the respondents applied the principles of engagement, which were awareness and interpretation of body language and how to measure the emotional climate within the patient's room. Another conclusion was 92 per cent of the respondents felt that they nursed with "an open heart and open mind" (p. 263), which for the authors signalled their willingness to give of themselves when caring for their patients. These findings supported Patch Adams' (2002) ethos of clowning being a love strategy, combining love and humour. For him, humour is a combination of fun and laughter, whereas love is the practice of compassion and generosity, as detailed by Auerbach et al. (2016). Adams felt clowning should not be considered a specialism as it may exclude the people who are present in the care setting (patients, staff, family members and so on) from its undertaking, thus discouraging their participation in co-creating the humour context.

2.4 Humour: social lubricity and abrasiveness

McCreaddie (2008b) recognised humour as a social phenomenon, occurring between two or more people, and that it plays a role in human interactions; as Snowden (2014) suggested, the sharing of humour builds relational foundations. This assumption has been supported by Caudill and Woodzicka (2017): their study

on humour, social support and well-being posited those who used positive humour as a communication tool were perceived to have more social support. Throughout nursing literature, the promotion of the principles of effective communication is widespread in an attempt to prevent further failings in patient care due to miscommunication (DH 2010; NMC 2015). McCreddie and Payne (2011) highlighted the use of humour and potential risk when using it within a nurse–patient interaction and how it can be linked with miscommunication. Therefore, since this study is concerned with student nurses experiences of humour, this necessitates further exploration of humour in the social interactions in which student nurses are involved, whether with mentors or patients.

Martineau (1972) formulated that humour can be used as an abrasive or lubricating tool. For him, social interactions constitute the everydayness of social routine and order, so using humour as a social lubricant can initiate these social interactions and keep them flowing. This, Martin (2007) argued, maintains harmony and stability. Conversely, the abrasiveness of humour can act as a block to social interactions. Martineau concluded that humour within social interactions can promote cohesion, provoke conflict and provide control. Janes and Olson (2015) detailed the need for social groups to maintain a positive identity, which they (2010) maintained can encourage groups to use disparaging humour in order to establish and maintain their superiority.

Martineau's (1972) three summarised functions of humour are: to increase group solidarity, the control of group behaviour, and to cause disintegration of the group. Table 2.3 demonstrates the abrasive or lubricating effects of humour on groups.

Table 2.3: Abrasive or lubricating effects of humour on groups

Lubricant	Abrasive
Solidify in-group Improve morale Foster consensus Increase social integration	Foster disintegration of intergroup relationships Create a hostile disposition to out-groups Control the behaviour of the in-group

(Ferguson and Ford 2008; Janes and Olson 2015)

The simultaneous abrasive/lubricating effect of humour could be illustrated in the feelings of the groups: one group (in) feels united whereas the other group (out) feels disparaged.

Others have considered the function of humour within a social interaction to include: searching for and giving of information; being able to critique without causing offence; allowing your counterpart to save face by saving them embarrassment or deflecting conflict; promoting group cohesion or reaffirming insider/outsider status; and giving information as in advertisements which gain attention (Kane et al. 1977; Robinson 1977; Foot and McCreaddie 2006; Romero and Cruthirds 2006; Martin 2007).

Earlier humour studies, such as Kane et al. (1977), maintained that humans probe the social surroundings to determine others within it. One probes for others' values and their attitudes towards certain topics such as disability or racism, their knowledge, emotional states and intentions (Martin 2007). Coser (1959, 1960, 1962) noted that humour is used in group hierarchies to maintain the status quo by controlling others' behaviour. Conversely, humour can function as a group cohesive agent through the use of insider jokes, which can arguably create a barrier to people outside of the group (Fine 1977).

2.5 Humour as identity

This section considers humour as a part of a person's identity, whether it be social or personal. Social identity, as noted above, arises from the groups one belongs to, for example one's sex, religion, ethnicity, and personal identity comprise personal tastes, bodily attributes and so forth (Hay 1995). Several authors have recognised individual influences, such as gender, age or culture, on one's humour creation, recognition, understanding, appreciation, and usage. This aspect of humour is important for student nurses since they will be expected to have and develop the knowledge, skill and attitude to effectively communicate with all members of the general public, who may become service users (NMC 2015). Therefore, in using humour a nurse must recognise his/her own humour individuality and the individuality of the patient with whom he/she is interacting, as well as recognising the

context in which the humour occurs. This discussion focuses on the following aspects of 'identity': gender, age, culture and ethnicity, the workplace and education.

2.5.1 Humour and gender

Several authors alluded to early research studies on the differences between the humour use of males and females (Kotthoff 2006; Martin 2007). Kotthoff (2006) maintained that no humorous activity is gendered but it can emphasise gender. She explained that traditionally held views involved actively joking men and a passive audience of women. Crawford and Greesley (1991) described how women were considered to have no sense of humour. These gender stereotypes perpetuated the long-held viewpoint that males are funnier and more likely to use aggressive or sexual humour than women (Sheppard 1977; Crawford and Greesley 1991; Cernerud and Olsson 2004; Dyck and Holtzman 2013).

Across the literature, much attention has been given to gender in comparison to humour activity and function. Table 2.4 below offers a synopsis of the ascribed humour activity and function per gender.

Table 2.4: Humour activity and function per gender

Male		Female	
Humour activity	Function	Humour activity	Function
Sarcasm Hostile teasing Ridicule Sexual humour	Supportive Create positive self-image Impress others Appear funny Solidarity Being competitive	Anecdotal Reminiscences Friendly teasing Self-deprecation	Supportive Create intimacy and cohesion Solidarity

(Tannen 1990; Lampert and Ervin-Tripp 1998; Hay 2000; Romero and Cruthirds 2006; Dyck and Holtzman 2013)

Hay (2000) identified that, in addition to the speaker's gender, group composition and the degree of publicness also influence the use of humour. Using data from single-sex and mixed-sex informal conversations, she asserted similar types of humour were used within single-sex groups but different uses occurred in mixed-sex company. She established that men tend to use humour to cope within the current conversational context whereas women use it to cope with non-contextual problems.

By utilising humour, a speaker gained the group's attention and controls the encounter (Hay 2000). Men, Hay (2002) noted, tended to achieve this more through performance-orientated humour. She explained men used fantasy humour especially in mixed-sex company, or word play (showing a competitive side through puns, disrupting the conversation and casting the limelight momentarily on themselves). Hay (2000) discovered men used humour more in public because being witty is central to a positive identity (one impresses which in turn elevates one's status within the group). Overall, the act of drawing attention to oneself highlights the 'power' dynamic of humour, an aspect of Hay's framework (see Table 2.2).

In Hay's (2000) findings, teasing usage decreased within the mixed-sex group, although, interestingly, she noted that the teasing that did occur was generally aimed at the opposite sex. She rationalised that in the presence of the opposite sex behaviour is affected by politeness or gender stereotypes (for example 'swearing is unladylike' or 'women are present'). This explanation extended to the use of insults and vulgarities, which were higher within same-sex groups but were markedly lower in the mixed-sex group (Hay 2002). Using teasing as a function to build single-sex group bonds was more likely to occur in the male group of friends. Marra and Holmes (2002) explained that humour can set boundaries between the sexes. Teasing, for Kotthoff (2006), has the function of cooperation and attack; Boxer and Cortes-Conde (1997) described it as having the ability to bond or bite. Both of these further supported Hay's (2000) conclusions regarding the dichotomy of teasing.

The women tended to share through anecdotes, preferably in private, but did not have the monopoly on this usage in mixed-sex company: in this context, the men's use of anecdotes increased. A more likely occurrence within the male group was to reminisce or highlight similarities to build their group bond (Hay 2000).

Martin (2007) explained that, when self-reporting questionnaires are used for studies, spontaneously occurring conversational humour is often discounted. He further pointed out that within such studies there was a gender bias (they were more male-humour orientated) in the selection of humour stimuli. Crawford and Greesley (1991) offered another limitation: it is the participants' responses to humour rather than their creation of it that was considered.

Within healthcare empirical studies, Dean and Gregory (2005) concluded gender and ethnicity both play a role in the use of humour. In their study, the participants alluded to humour being a way for men to be open with each other or to cover up their felt discomfort, a dynamic also seen in Otliffe et al. (2009). This echoed Astedt-Kurki and Isola's (2001) study in which men avoided or postponed a difficult emotional situation by using humour as a defence mechanism. In Chapple and Ziebland's (2004) and Otliffe et al.'s (2009) studies of male cancer sufferers, the authors suggested that humour use afforded group cohesion and built solidarity whilst enabling emotional management of anxiety, tension and embarrassment. In Clark's (2017) grounded theory study of female breast cancer sufferers' emotional turmoil (as related to physical disfigurement), she revealed they used sexualised joking about their bodies, especially their breasts, to bring to the fore their discomfort without having to tackle underlying issues. This face-saving mechanism allowed them to appear strong. Moreover, Clark concluded the women used humour as a coping strategy by targeting the changed areas of their bodies. These conclusions supported Rose et al.'s (2013) phenomenological study findings, based on recurrent ovarian cancer sufferers' use of humour. This earlier study revealed that their participants used humour to cope by using their diagnosis as a basis for their humorous comments, making them feel less anxious.

Crawford (2003) cautioned against an over-simplistic representation of gender as Hay (2000) demonstrated both genders use humour to create feelings of solidarity (as well as use it creatively), maintain the real-life context and caring (Crawford and Greesley 1991) and maintain or achieve status within the workplace (Holmes and Marra 2002b; Holmes 2006). Therefore, no simple humour classification between genders can be drawn regarding creation, appreciation, type or purpose of humour. Kotthoff (2006) illuminated it is not only gender which influences humour but also age, specifically in the freedom it gives. The discussion moves now to focus on humour and age.

2.5.2 Humour and age

Many authors have highlighted the influence that age exerts on one's use of humour, whether looking at its cognitive function or its social purpose. Tennant (1990) proposed one of life's most valuable assets is the ability to see humour in ourselves

and situations. The role of humour within different stages of life varies according to cognitive development, the ability to communicate and the biological influences of ageing, as well as serving different functions within one's lifetime (Martin et al. 2003).

Epstein's commentary (2012, p. 42) reminded us that old age occurs in everyone and declared it to be the "most democratic institution going – nearly everyone gets to enjoy it". He recounted life as "a ride from goo-goo to ga-ga" (p. 45).

Several authors have compared older adults with younger adult counterparts in areas of humour production and appreciation. Ruch et al. (1990) suggested older adults appreciate incongruity-resolution humour (it is not the incongruity of the humour used which is humorous, rather the resolution of the incongruity, Ritchie 2011) more than their younger counterparts, finding it funnier than nonsensical humour. However, as time progresses, problems with understanding the incongruity can occur, leading to a decreased enjoyment in either humour form for the older adult (Greengross 2013). Both Herth (1993) and Buckwalter et al. (1995) detailed older-adult humour as incorporating more than joke-telling; rather it can be a gentle recounting of every day amusing tales of children or pet antics.

Herth's study (1993) described influences on an older person's receptivity to humour; these include age (as detailed above), place of residence (as older people in care homes rely on busy staff for the social interactions) and level of health (as levels of frailty influence the type and function of humour). Nonetheless, Vaillant (2004) suggested predictors of successful ageing include the use of mature defence mechanisms, one of which is humour, therefore aiding/achieving the goal of positive ageing: "to add more life to years than years to life" (p. 561).

2.5.3 Humour, culture and ethnicity

The universality of humour is well documented in humour literature (Campinha-Bacote 1995); no society or culture is without it (Alford and Alford 1981; Wooten 1997). Common themes relating to culture, such as having a disability or sexual orientation, and ethnicity, such as racial differentiation, can be categorised into an intra/intergroup (Apte 1987). It is recognised that people can be part of many groups; a man might, for example, identify as black, disabled and gay. However, there may be times when an individual feels part of an 'out' group due to humorous

occurrences as one group identity can be made the butt of the joke. Then they may no longer feel part of the original group.

Goldstein (1977) highlights the trend in humour literature to assume cultural universalism, whereby humour is generalised from western to eastern cultures. Even assumptions such as Western cultures being homogenous are made; however, this generalisation of humour is opposed in studies such as Martin and Sullivan (2013). In their comparative study of British (n=42), Australian (n=50) and American (n=50) participants. They conclude British respondents held significantly more negative views towards humorous people than Australian counterparts, whilst the American respondents used humour more readily in social situations than the British participants. Therefore it can be suggested national differences of humour, in certain areas, exist even within considered homogenous groups, such as Westerners.

Further comparison between Western and Eastern cultures' use of humour posits Chinese cultures have a more implicit negative view of using humour, and rely less on humour as a coping strategy than Western counterparts (Chen and Martin 2007; Jiang et al. 2011). In Jiang et al. (2011) the Chinese students rated humour appreciation similarly to their American counterparts, yet Chen and Martin (2007) note, in their study, they behaved less humorously than the Canadian participants. Furthermore Chen and Martin highlight the Canadian participants assigned more importance to having a sense of humour (desirable personality trait), demonstrated in using more types of humour than their Chinese counterparts. Jiang and Yue (2011) suggest the Chinese participants' reported view of humour is influenced by Confucian teachings; they argue that Confucius, a prominent philosopher, considered laughter to be a symbol of illiteracy and the use of humour to symbolise one as being uncultivated.

Chiang-Hanisko et al. (2009) offer another point of consideration on the cultural perception of humour. They use the example of how Western cultures' expression of humour gives value to individualism, reflected in the prioritisation of an individual's needs over the group (evident in individuality, competitiveness and independence) as noted by Kazarian and Martin (2006). Conversely, Eastern Cultures' humour expression reflects collectivism, namely the interdependence of people and the

prioritisation of a group's needs (reflected in the emphasis placed on harmony and seniority) (Kazarian and Martin 2006; Chiang-Hanisko et al. 2009).

In Chiang-Hanisko et al.'s (2009) cross-cultural study of the teaching of therapeutic humour by American and Taiwanese nursing educators, they conclude Taiwanese colleagues concentrated more on the theoretical teaching of therapeutic humour due to the cultural norms ascribed to the gravity of illness and the kinship system of the family and patient being "one entity" (Chiang-Hanisko et al. 2008, p. 57). For the American colleagues, more humour was experienced within the clinical setting (and with spontaneity); therefore, it became more person-centred, as seen in individualistically orientated societies.

Thus far the discussion has been on national differences in humour appreciation, yet Robinson (1977) suggests popular humour is used as a cultural tool to express conflicts, concerns and aspirations as supported by Campinha-Bacote (1995). In his discussion paper titled "Ethnic humour", Mintz (1977) claims ethnic humour serves two functions: hostility (mask, defuse or a sanctioned means) and group identity (reinforce own group or prejudice against other). Apte (1987) debates the juxtaposition of two key cultural values: sense of humour (a key positive attitude when one is prepared to laugh with or be laughed at), and ethnic humour (defined as making fun of an individual or group based on their sociocultural identity) or 'put-down' humour as described by Campinha-Bacote. As many ethnic groups seek to maintain characteristics of their heritage whilst functioning within the main society (Holmes and Hay 1997), Apte (1987) notes ethnic groups' increased ability to challenge ethnically derogatory humour about them within the public domain. Therefore, the inward (insider) use of humour within an ethnic group differs to the outward (outsider) use of humour; hence it is the audience which makes the difference (Apte 1987). Campinha-Bacote (1995) notes the role and type of humour within an ethnic group cannot be duplicated by an outsider as it can be deemed to be disparagement, which suggests reinforcement of stereotypes and bias, and maintains the dominant group's control.

The issue as to whether disparaging humour reinforces stereotypes (Foot and McCreaddie 2006) or solidifies group cohesion can depend on whether one is the target or not. Zillman and Cantor's (1976) dispositional theory of humour and mirth

proposes that the amount one laughs at disparaging humour indicates the amount of dislike or contempt one holds for the target group. Ford et al. (2015), in their review of empirical studies on disparagement humour, conclude that exposure to disparagement humour does not influence the existing viewpoint held of the target group. However, based on their prejudiced norm theory, they propose that the disparagement humour can offer release of prejudice without fear of social reprisal. Therefore, in any particular context one can be probed about societal norms whether this type of humour is acceptable or not, ready to say 'I was only joking' if the use of disparagement humour backfires. Historically disparaged groups criticise the use of this type of humour as both its usage and the derogatory opinions within the humour may become the accepted norm.

Davies (1982) details how ethnic jokes, especially ones about stupidity, are widespread across the globe. In his book, *The Mirth of nations* (2002), he compares several groups (Jews, Scots, Poles, Newfoundlanders, and Americans) in which he explains jokes measure, rather than set, societal opinions. He maintains self-mocking jokes are enjoyed by the 'mocked' group and can be self-affirming and promotive. Further considerations on ethnic disparagement were dealt within a collection of essays by a group prominent humour scholars (Davies et al. 2008), in light of the adverse consequences (physical violence) following the publication of the Prophet Muhammad cartoons by a small Danish publisher (with anti-immigrant views). In Davies's own essay (Davies et al. 2008), he reinforced his notion that a joke is not the cause of aggression, rather it is the recipient's response to the offense taken (and how this can be amplified and can be used as a political weapon) which produces such consequences, for example rioting. In his play, *The Blasphemer*, Curzon (2017, p. 61) detailed how "one man's blasphemy is another man's good time". Furthermore, Davies highlighted the win-win of the above cartoon controversy for both groups in this case (publisher and Muslims) but Davies considered it a loss for both parties as it reinforced tough governmental laws on immigration and revealed the current sentiments of many within the Muslim community to the wider Danish and global community. Foot and McCreddie (2006) maintain the power of disparaging humour based within cultural myths is potentially underestimated.

2.5.4 Humour and the workplace

Establishing one's social identity potentially includes occupational group membership; for student nurses in particular, therefore, this connects with the students' future workplace, the clinical setting. This is often considered a serious place due to the daily tragedies, suffering and joys experienced. It is also here that the students will forge relationships with peers, staff and patients, and building relationships, as Holmes (2006) explained, is one of the primary functions of humour use in the workplace. This section sets out to elicit commonalities of humour use across various workplaces. Two aspects within the workplace that influence the use of humour are the serious nature of the workplace and the inter-relational dynamics between people in peer-to-peer interactions and group dynamics (Martin 2007; Holmes 2007). In these, the positive/negative duality of humour can be observed as Cooper (2008) illustrated: humour has the capacity to create and maintain, or hinder and end, relationships.

Humour is big business, as shown in the previous sections; in contemporary workplaces its usage is often planned, with research detailing its potential as a work tool (Duncan and Feisal 1982). However, as Martin (2007) pointed out, there tends to be an over-emphasis on the positivity of humour and its associated benefits (in relationships, critical thinking, performance and creativity) as being open to new ideas may influence one's risk taking capacity, job satisfaction and stress management. These planned humour interventions focus on play because it is thought that, by unleashing creativity, problem solving increases which enhances work performance. Duncan and Feisal (1982) proposed that a false dichotomy exists between the seriousness and playfulness of the workplace, as the participants in their study were able to recognise the significance of humour in the workplace, and they suggested that work can and should be fun.

This importance has been recognised in various studies investigating the occurrences of humour within business meetings (Consalvo 1989; Vinton 1989; Holmes and Marra 2002a; 2002b). Holmes and Marra (2002a) compared the frequency of humour in various workplaces. This revealed that factory and private settings used humour more frequently than the governmental and semi-private organisations (although laughter occurrence between colleagues was every two to

five minutes in the various workplaces). Holmes and Marra (2002a) rationalised the seriousness of the governmental and semi-private organisations could be due to the particular responsibilities and accountabilities that these two institutions carry. Martin (2007) concluded such occurrences give an insight into the organisational culture, that is, into the group's norms, values and behaviours, which Duncan and Feisal (1982) proposed is an antecedent to using humour. Holmes and Marra (2002a) explained that it is into this organisational culture that new employees will be socialised, therein developing a social identity and learning its associated behaviours which can manifest into a sense of belonging or exclusion when dealing with humour within group situations (Vinton 1989; Sanders 2004). This is applicable to both institutional and non-institutional settings.

As a new employee or member of a friendship set, his/her status within a group can determine how humour is used by others (for or against). Numerous studies highlighted the use of humour to establish group identity as a means of showing solidarity which either strengthens the group bond or disparages outsiders (Holmes 2000; Sanders 2004; Martin 2007). Within the vertical power relationships, there is a general acceptance that those in lower-ranking positions tend not to use humour with superiors (Coser 1959; Pogrebin and Poole 1988), although Duncan and Feisal (1982) proposed it is not hierarchical status which determines one's involvement in jocularities but rather one's group status based on trust and respect. However, Holmes and Marra (2002b) established that the use of subversive humour by subordinates to legitimately challenge or to project their disagreements with authoritative figures can be socially acceptable; as Holmes (2000) indicated, this can save face for both participants. In Taylor and Bain's (2003) study of two call centres, extreme use of subversive humour in one call centre diminished legitimate authority, revealing a dissonance between the organisational goals and the workforce's intention of creating a trade union presence. This supports Holmes and Marra's (2002b) conclusion that, in the humour comparison of workplace and friendship groups on an individual, organisational and societal level, subversive humour (a type of humour which confronts power relationships) is present at all levels. Additionally, subversive humour occurs more frequently in meetings, and aids in distancing relationships within the workplace hierarchy.

In contrast, supportive humour is highlighted in Holmes and Marra's study (2002a), focusing on nine New Zealand organisations. They suggested the majority of the workplaces (governmental, semi-public and factory) used up to three times more supportive humour than contestive humour (that which "challenges/disagrees with or undermines earlier conversational content", p. 1687). It was only in the private organisations that more contestive rather than supportive humour was used, which were also characterised by single rather than extended sequences of humour. In other words, it tended to be more individualistic than collaborative in nature, which Holmes and Marra suggested correlates to the competitiveness of the workplace.

To this point, it is the formal workplace which has been this section's focus; however, in Sanders' (2004) study the role of humour within the sex industry was discussed. Sander's ethnographic study, conducted over a ten-month period, concentrated on females within the sex industry, both on the street and in establishments. She determined that a variety of humour strategies were used: private jokes (intended to mock the clientele), coded jokes (in the presence of the clientele), the sharing of anecdotes based on one's work life (this protected the women's family lives), humour as a resistance strategy (against harassment and aggression from outsiders), a 'currency' (professional banter between sex worker and various professionals, see below) and using it to manage conflict and group cohesion. Furthermore, she explained her participants used their "toolkit of detachment mechanism" (p. 283), which contained aggressive mockery and joking in relationships. Using elements of superiority humour to distance oneself is explained by Lefcourt et al. (1974) in terms of the internal/external locus of control. Ford et al. (2016) maintained people with an internal locus of control carry a belief that they have control over the outcome of events, in most situations, whereas people with an external locus of control rely on fate, luck or chance and often blame others for outcomes (for example, their teachers if they experience poor exams results). Returning to Lefcourt et al., they established people with internal control were more likely to use distancing humour to remove themselves from the immediate experience in order to decrease the level of vulnerability which could arise from the situation. Ford et al. (2016) continued that people with a strong internal locus of control are more likely to be happier and have higher self-esteem.

Sanders' findings are similar to Holmes and Marra (2002b) in that her participants learnt and consciously used humour as a distancing strategy, determining 'in' groups (such as with other sex workers) and 'out' groups (such as with clients). She also concluded the sex workers used humour as a means of coping, especially with the emotional aspects of their work, which she compared to healthcare workers' adoption of a façade to protect their private self.

Sanders (2004) observed that drugs workers and healthcare professionals were some of the professional groups her participants encountered. Humour was used with them, in the form of banter and anecdotes, to transmit personal information that might highlight their vulnerability to danger and difficulty. She called humour a "currency" (p. 280) through which support, advice and advocacy can be given. Humour as a currency has been previously noted in McCreddie (2010), who illustrates the atypical professional viewpoint: she recounted how one participant used spontaneous harsh humour with a vulnerable at-risk client (drug user) and successfully conducted an ante-natal examination.

Working with at-risk groups can be stressful and reliance on colleagues is paramount. McCreddie (2016) illustrated that peer support through harsh humour in such settings can seem cold and harsh to the outsider. She suggests that this type of humour can be recreational (building solidarity amongst colleagues to face the challenges) or be releasing (helping emotional management and resilience) to the individuals involved. She concluded that being confident in one's own communication style and professional awareness of the risk in using such humour is paramount.

To this point, there is an underlying assumption that all workers have the same expectations of their workplaces, yet Romero and Cruthirds (2006) detailed how generational groups of workers have different aims and ambitions across their careers. According to Rigoni and Adkins (2016), millennials place more significance on organisations that help them grow and advance rather than offering an informal, creative or fun atmosphere. Future nursing students are from Generation Z, born from 1995 to 2012 (the technologically savvy group), who value diversity and practical applications and have a limited attention span, a pragmatic approach to life

and perhaps lower work expectations (Hampton and Keys 2017). Their perception of humour in the workplace needs further investigation.

2.5.5 Humour and nurse education

Banas et al.'s (2011) review of four decades of humour within general educational settings concluded there is a dearth of contemporary studies. Furthermore, the authors identified that the majority of studies, in addition to them being outdated, are located in the USA; therefore, according to Scheel (2017), cultural differences make transferability of findings to other countries difficult.

Current assumptions are that the use of positive and appropriate humour makes the classroom (learning environment) more relaxed, and makes the students happier, more able to retain information and generally more motivated (Martin 2007; Scheel 2017; Gonulal 2018). Banas et al. (2011) recommended only using the humour that one is most comfortable with and which best fits one's own humour orientation and culture.

According to Martin (2007), Banas et al. (2011) and Scheel (2017), the problematic types of humour are degrading remarks, offensive humour (sexual, racial, cynical) and using humour excessively. These authors shared a consensus that teachers should not use aggressive (sarcasm, teasing, 'put-down' humour and ridicule) or tendentious humour as a corrective measure, even for short-time use, due to the student-based consequences on a cognitive, social and emotional level (Scheel 2017). Table 2.5 demonstrates the functions of classroom humour based on social, cognitive and emotional elements.

Table 2.5: Functions of classroom humour based on social, cognitive and emotional elements

Social	Cognitive	Emotional
Positive	Positive	Positive
Fosters learning if linked to course content Creates positive attitudes to learning Makes learning enjoyable Makes the classroom less threatening for the students Promotes creativity and critical thinking skills Stimulates interest and attention to educational message Increases cognitive skills	Enhances student–teacher relationships Immediacy – decreases social distance Ability to indirectly influence people Increases morale Builds trust Decreases fear/tension Approachability of teacher Status maintenance Norm enforcement Increases teacher’s likeability	Ability to cope Increases motivation Empathy – makes the teacher seem more caring Promotes a sense of community Reduces negative feelings
Negative	Negative	Negative
Information is unrecalled if not linked to course content May not increase performance or effectivity of learning	Ridicule – fosters an, inhibited, conformist fearful and anxious emotional climate where students are less likely to take risks Decreases teacher’s creditability	Increases social distance Increases negative feelings Negative influence on student’s self-image, esteem, and motivation

(Banas et al. 2011; Martin 2007; Scheel 2017)

Drawing from a small selection of frequently cited nursing education studies, nurse educators have recognised the functions and consequences of humour in learning. The learning relationship between the nurse teacher and student nurse, influenced by the learning environment, is paramount when optimising student learning opportunities (Ulloth 2002a; 2003a, 2003b; Chiarello 2010). Chiarello (2010) commented that the teachers’ sharing of their clinical anecdotes allowed the novices to learn both from their own mistakes and those of their tutors. This was considered to empower the students.

The focus of Ulloth’s study (2002a; 2003a) was on the intentional humour of three pre-selected nurse teachers who used it as a tool. Her conclusion was that humour relieved stress, focused attention, made learning fun, assisted learning and strengthened social relationships. These teachers pre-planned lectures to include humour, which made the classroom both fun and focused on the course content, which was presented clearly. Chauvet and Hofmeyer (2007) highlighted inter-

generational communication differences as a potential factor influencing the teacher's felt immediacy. Watson (1988) maintained that if humour is included within the lesson plan, then a caring atmosphere exists, therefore allowing the bi-directionality of communication. Ulloth (2003b) suggested that a teacher should encourage students to contribute to the humour climate because active participation creates an informal, stress-reduced learning environment. Chauvet and Hofmeyer suggested using humour within a problem-based learning environment enables students to transfer positive coping strategies to the everydayness of nursing. Kuhrik et al. (1997) highlighted how student humour use can signal problems, for example using humour excessively can indicate problems; using cynical humour or satire can mean unhappiness or decreased self-image whereas an absence of humour can mean stress within the group.

Banas et al.'s (2011) review on humour in education demonstrated the recurring theme of the teacher's perception of humour use and its threat to their professionalism and creditability if they are considered unserious because of their humour use, or if they use inappropriate humour. The theme of creditability and professionalism being linked to one's use of humour is in keeping with Jones and Tanay's (2016) review in which nurses' general perception is that it is unprofessional to use humour since it brings their competence into question.

Banas et al. (2011) suggested the possibility that other differences between teachers might affect their use of humour, namely the sex of the teacher and their experience (more experienced teachers are more likely to use humour).

2.6 Humour: the complexity

To this point, this chapter has identified the complexity of humour. However, there is a need to present a humorous occurrence within the context of social interaction. The diagram below (Figure 2.3) represents the combination of factors which may be at play within the student's experience of humour, which is a non-linear process. This diagram shows the individuality of humour, which in turn influences the setting up of the occurrence, the audience's response and how humour support strategies are engaged within this one interaction.

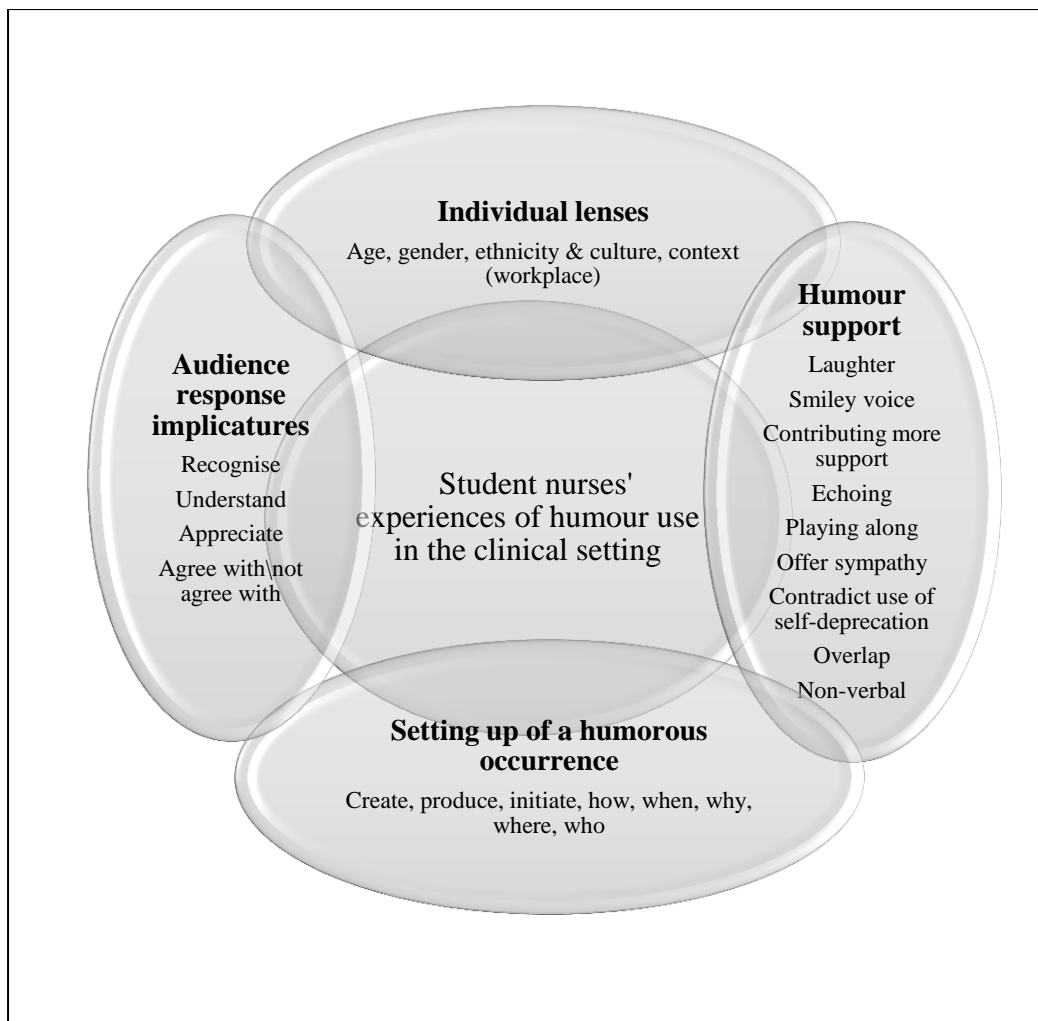


Figure 2.3: Humorous occurrence within a social interaction

Figure 2.4 represents what is termed 'the practicalities' of humour (presented separately from Figure 2.3 for readability). These include the functions of humour and a variety of its types.

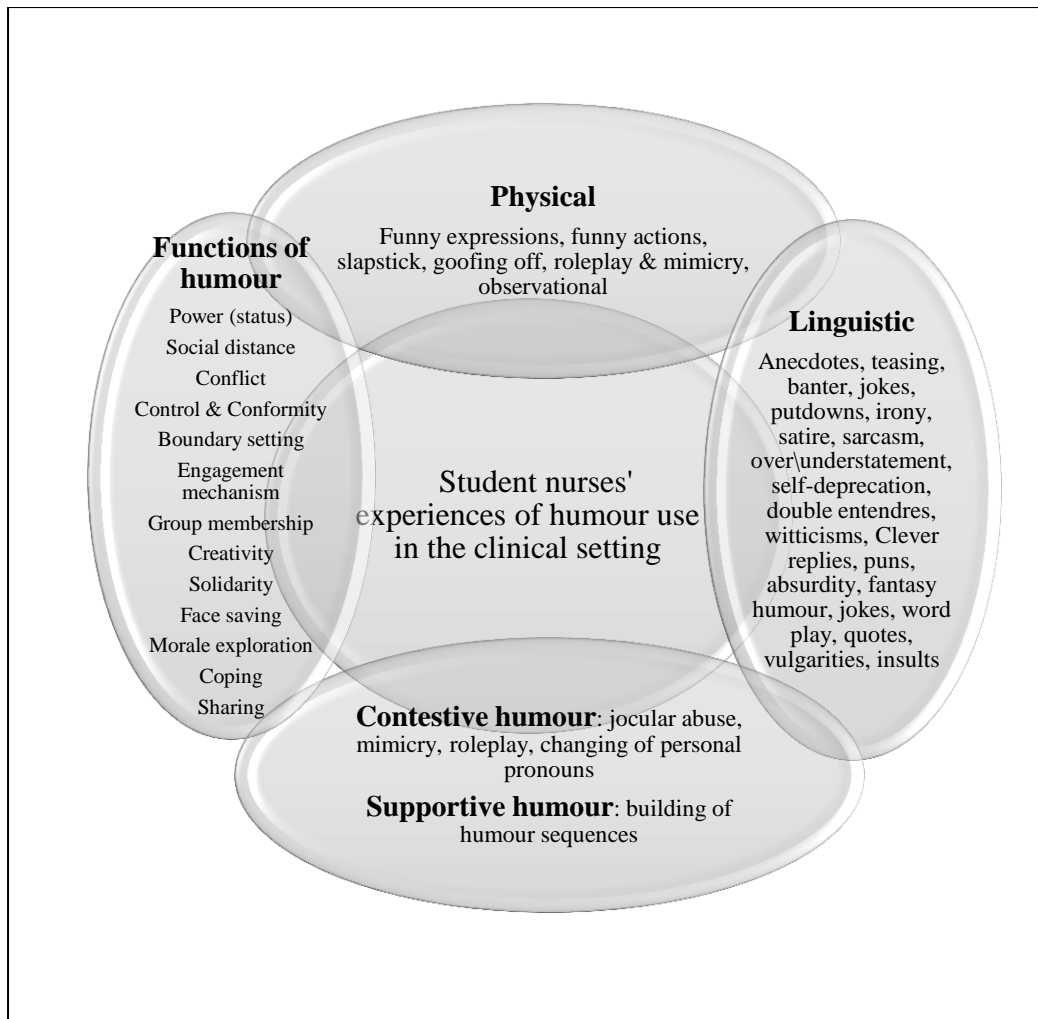


Figure 2.4: The practicalities of humour: Types and function of humour (Martineau 1972; Duncan and Feisal 1982; Feigelson 1989; Morreall 1991; Hay 2001; Holmes and Marra 2002a, 2002b; Romero and Cruthirds 2006; Martin 2007; Bolton and Houlihan 2009; Dynel 2009)

The preceding sections demonstrated the extent of humour across individuals, organisations and society, and its influence on an emotional, cognitive and social level. Commonalities of humour type and function, the influence of an individual's demographics and often the simultaneous duality (negative/positive potential) influencing social interaction were identified. These were underpinned by the ever-changing meaning of the word 'humour' and the evolution of humour theories within the historico-political context.

2.7 Relevance of this chapter to student nurses and this thesis

This chapter has explored key understandings of humour that draw attention to the effects humour can have, the way humour is utilised and the various influences on

the individual's perceptions, experience and use of humour. It has also shown that a greater understanding of humour and the ability to recognise humour can potentially improve the care a nurse is able to provide. Another contribution would be the contextual understanding of humour in regards to where, when and with whom humour occurs, which would add to the student nurses' understanding of humour and the risks involved in humour use in certain situations.

There is a scarcity of humour studies based solely on student nurses' experiences of humour use in the clinical setting within the UK. This thesis seeks to address this dearth by beginning to understand these experiences and the influences humour has on the relationships/interactions the student nurses have with people in their daily practice (patients/RNs).

2.8 Definition of humour for this study

The multidimensionality of humour makes it difficult to define, and the definition adopted for any study depends on how humour is viewed (Scheel 2017). From the perspective of this study (student nurses' experience of humour use within clinical settings), it is the relational aspect of humour which warrants investigation, as the students will be in constant contact with their mentors, other staff or patients. As individuals, holistic beings shaped by life experiences, the students may not know the theories of humour but still claim to possess a sense of humour. Snowden (2014) explained that influences on humour interpretation are its context and the personal interpretation, based on age, gender, ethnicity and so forth. Laughing at others, ourselves, situations or funny incidents and solving incongruities within verbal humour highlight claims that human beings are the only species to have the ability to develop a sense of humour (Gordon 2010).

Robinson (1995) explained humour within nursing is a missing element because of the socialisation of nurses to exhibit a professional demeanour, which includes not laughing or using non-sanctioned health-based humour (such as gallows humour). Additionally, inappropriate use of humour could potentially be experienced by service users as abuse. Yet Robinson maintained humour is a form of communication which "facilitates all social relationships and manages all the delicate situations which can occur" (p. 15).

Common elements in past definitions of humour include it being a goal-orientated communication strategy, containing verbal and non-verbal elements with intra- and interpersonal functions, being used intentionally or spontaneously (with an affective outcome – positive or negative) and exerting social influence (to produce distance or intimacy) (Booth-Butterfield and Booth-Butterfield 1991; Scheel 2017). Hay (1996) debated the issue of humour definition, shedding light on two features: intention (of the speaker) and interpretation (of the audience). Scheel (2017) criticised any definition focused only on the interpretation of the audience; therefore, any definition must include both the initiator and the audience.

As discussed within the prologue and this chapter, humour has the potential to harm or heal, yet this thesis maintains that within such potential the positivity of humour outweighs its negativity. This study's definition of humour adapts Romero and Cruthirds' (2006, p. 59) definition of organisational humour (itself based on Martineau 1972, and Crawford 1994). Therefore, for the following discussion, *humour consists of amusing communications intended to produce positive emotions and cognitions in an individual or group.*

2.9 Conclusion

This chapter created a backdrop for understanding the complexities and enormity of the humour field, underpinned by three main theories. Within the nursing field, the focus of humour research has been predominantly on the RN, yet each RN undertakes a period of education to achieve this. Therefore, the relevance of this thesis is in examining the nursing students' experience of humour within this educational phase and beginning to understand the meaning their use of humour has and whether it is affected by these experiences within professional practice. Alongside this, the topic of humour and student nurses within the United Kingdom is in its infancy; therefore, this thesis establishes a starting point.

The next chapter offers a review of the literature centred on humour, nursing students and the clinical setting.

Chapter 3: Capturing the essence of humour in healthcare – a literature review

The aim of this chapter is to capture the essence of humour within healthcare whilst placing this study into context with what is already known, by providing a comprehensive narrative review. Beginning with the search strategy used, the focus of the chapter then moves to the exploration of the identified themes, which results in identifying any gaps within the humour literature.

The purpose of a narrative review is to identify and review past literature on a certain topic (Ferrari 2015). However, a common critique of such a review has been the subjective bias of the literature searched (Hodgkinson and Ford 2014); therefore, Ferrari (2015) recommended adopting the systematic methodologies used in systemic literature reviews to improve the quality and reduce the bias of a narrative review. Holly (2012) detailed the steps for conducting a systematic literature search; these steps, interwoven with Hamdy et al.'s (2006) search strategy, are applied in the forthcoming sections of this chapter.

3.1 Planning of the search strategy

Both Methley et al. (2014) and Beecroft et al. (2015) stated that a review of the literature targets relevant papers to capture current literature sources that aid in establishing what is known about the research phenomenon. Methley et al. (2014) suggested adopting an organising framework, or a search methodology, which can assist in formulating the final research question (Holly 2012).

Search methodologies are often presented in mnemonic format, such as PICO, PICO, SPICE, or SPIDER (Joanna Briggs Institute [JBI] 2011; Holly 2012; Methley et al. 2014). Table 3.1 highlights what each mnemonic stands for.

Table 3.1: Meaning of search methodology mnemonics

Mnemonic					
PICO	Population	Intervention	Comparison	Outcome	
PICO	Population	phenomena of Interest	Context		
SPICE	Setting	Perspective	Intervention	Comparison	Evaluation

PICO is an established search methodology for quantitative reviews and is usually used with clinically based questions (JBI 2011; Holly 2012; Methley et al. 2014), whereas PICo is a search methodology for qualitative reviews which Holly (2012) explained is used for studies interested in meaning. This study is focused on the experiences of students regarding humour within their clinical placements. This interest is derived by my philosophical underpinnings, which are discussed in chapter four. So, PICo is the methodology of choice.

3.1.1 Aim and objectives of this study

The aim of this literature review was to establish what is known about this study's research question: 'How do pre-registration nursing students experience the use of humour in the clinical setting, within the United Kingdom?'

3.1.2 Inclusion and exclusion criteria

The inclusion criteria identified for this study's literature review were as follows.

Types of participants

These were pre-registration nursing students participating in research studies focusing on humour. The students had to be currently enrolled on a pre-registration health-related programme.

Phenomenon of interest

The phenomenon of interest for this study was humour.

Context

International studies were considered due to the dearth of humour studies within UK healthcare literature. The setting of these studies was within the clinical setting, be it in a hospital or community setting.

Types of studies

Types of study considered for this literature review include quantitative only, qualitative only and mixed methods regardless of design.

Exclusion criteria for this literature review were studies focused on:

- Professions other than healthcare
- Certain types of humour; formulaic jokes involving sexism, racism, political or aggression
- Rehearsed humour, such as nurse–clown workshops
- Physiological effects of humour
- Disease-focus that is focused on the humour–health hypothesis (McCreddie and Wiggins 2008)
- Children
- Classroom teaching.

As established in chapter two, humour has been the focus of many philosophers across the ages; however, a time limit had to be set, so for this literature review publications prior to 1919 were excluded, since this is when the Nurse Registration Act was enshrined into UK law. Only studies in the English language were considered.

3.2 Search strategy

A three-step approach was used to identify extant literature on pre-registration students' humour use within the clinical setting. The three steps were: broad scoping; full electronic and non-electronic scoping; and a screening stage (Hamdy et al. 2006). In order to eliminate potential researcher bias, this search was conducted once the analysis of the interviews was completed (Holly 2012).

The broad-scoping search undertaken identified a few relevant articles; however, none were found when restricted to the United Kingdom. Discovering a paucity of literature on nursing students, the review was expanded to include pre-registration students from all healthcare disciplines.

3.2.1 Identification of search terms

The broad-scoping search began with the generation of preliminary key words from the research question. Articles obtained through this search were used to identify wider keywords and synonyms. MeSH headings were established with the help of an academic librarian.

3.2.2 Search strategy for full electronic scoping

Using the ProQuest and EBSCO research platforms to choose relevant databases, I began with a specific healthcare one: Medline. Table 3.2 outlines the search undertaken.

Table 3.2: Identification of search terms using MeSH headings and subject headings within electronic databases

Population.	Phenomena of Interest	Context
Pre-reg students	Humour	Clinical setting / on the job education / nursing practice
Undergraduate	Humo*	Nursing practice (MeSH)
Baccalaureate	Laugh*	Student placement (MeSH)
Degree	Cheer*	Education, clinical (MeSH)
Pre-registration	Light hearted*	Student experiences (MeSH)
Diploma	Fun*	
Students	Wit and humor (MeSH)	
Graduate nursing program		
Education, nursing, graduate (MeSH)		
Education, nursing, baccalaureate (MeSH)		
Education, nursing, diploma programs (MeSH)		
Professional education (MeSH)		

The yield from Medline was 418 when limited to English language and scholarly journals. Application of this same strategy repeated in Academic Search Elite and the British Nursing Index resulted in considerable higher yields (2,178 and 2,567, respectively); therefore, I decided to simplify the terms being used. Table 3.3 represents the new search terms applied and Table 3.4 represents the refined search terms.

Table 3.3: Identified search terms as used on Medline, following PICO

Research question term	Search term used from Table 3.2	Boolean phrase
Students	Undergraduate; baccalaureate; Degree; Pre-registration; Diploma; Students; Graduate nursing program; Education, nursing, graduate (MeSH); Education, nursing, baccalaureate (MeSH); Education, nursing, diploma programs (MeSH); Professional education (MeSH)	OR
Humour	Humo*; laugh*; cheer*; fun*; light hearted*; "wit and humour"	OR
Clinical setting	Nursing practice (MeSH); Student placement (MeSH); Education, clinical (MeSH); Student experiences (MeSH)	OR
When the full three parts of the research question were strung together it resulted in no yield, therefore only the first two parts were ran together		
(laugh* OR cheer* OR light hearted* OR MM "Wit and Humor as Topic") AND (Pre-registration OR undergraduate OR baccalaureate OR degree OR (MH "Education, Nursing, Graduate") OR diploma OR students OR (MH "Education, Nursing, Baccalaureate") OR (MH "Education, Nursing, Diploma Programs") OR (MH "Education, Professional"))		

Table 3.4: Refined search terms

Research question term	Search term used	Boolean phrase
Humour	Humour; humor	OR
Student	Student; undergraduate	OR
(Humour OR humor) AND (Student OR undergraduate)		

When needed, these search terms were further refined by limiting the search to the clinical placement.

The following electronic research databases were searched:

- Academic Search Elite
- ASSIA (Applied Social Science Index and Abstracts)
- BNI (British Nursing Index)
- CINAHL (Cumulative Index to Nursing and Allied Health Literature)
- Medline

- Psycho ART
- PubMed
- PyscINFO
- ScIndex.

3.2.3 Search strategy for non-electronic scoping

There is an abundance of editorials, commentaries and opinion papers within the nursing literature regarding humour; however, my focus remained on primary research studies. The focus of the non-electronic search was on known experts within the nursing literature (for example, McCreddie 2008b), along with hand searching relevant journals (since some databases restrict access to the more recent publications) and known articles' reference lists. This included the grey literature databases, SIGLE and OPEN Grey, for dissertations and/or conference presentations.

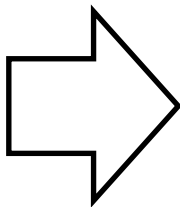
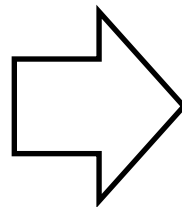
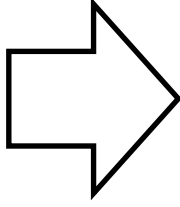
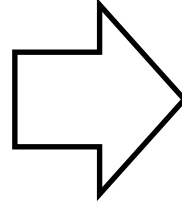
Another information source was the International Society for Humor Studies' reference website, available to members only, which provides recommended reading on numerous issues associated with humour. From the section titled 'Health, Humour and Medicine', 47 potential articles were identified. Following this, I conducted an individual search of the two humour specific magazines: *HUMOR* and the *European Journal of Humour Studies (EJHR)*. The search of *HUMOR*, for the years 2001–2014 accessible via my own university's website, identified eight articles. The search of the *EJHR* resulted in no appropriate articles based on nursing, medicine, or clinical keywords.

3.2.4 Screening process

The on-going screening stage, with its emphasis on relevant articles and their abstracts, allowed for elimination and appropriate procurement. Reading the obtained articles fully allowed for further scrutiny with regards to the inclusion and exclusion criteria. Many selected articles concentrate on the nurse educator in the classroom. As this was not the context of the research question, this led to an additional exclusion criterion being added.

This was followed by undertaking a methodological analysis of each article, using the JBI (2011) checklist for each research design. This critical analysis ensured the papers used were robust. Subsequent to this was a search of the chosen articles' citations, completed via Scopus and Google Scholar; this added no new primary research articles. Table 3.5 highlights the chosen articles.

Table 3.5: Results overview of database search (Adapted from Bennett 2016)

Database	Limiters applied	Initial yield		Papers selected for abstract screen minus duplicates		Papers included in review
Academic Search Elite	English Language, Peer reviewed, 1919–2016	794		15		Parsons et al. 2001
ASSIA	English Language, Peer reviewed, 1919–2016	86		10		Nil
British Nursing Index	English Language, Peer reviewed, 1919–2016	1723		40		Williams 2013
CINAHL	English Language, Peer reviewed, 1919–2016	206		34		Hayden-Miles 2002 Stein and Reeder 2009
Medline	English language	116		15		Nahas 1998 Wear et al. 2006
PsycARTICLES	Peer reviewed, 1919–2016	96		0		Nil
PsycINFO	English Language, Peer reviewed, 1919–2016	1120		13		Nil
ScoIndex	English Language, Peer reviewed, 1919–2016	153		4		Kaye and Fortune 2002
International Society of Humor Studies (ISHS)	English Language, Peer reviewed, 1919–2016	21		21		Rosenberg 1991
Nurse Education Today	English Language, Peer reviewed, 1919–2016	126		5		Nil
Nurse Education in Practice	English Language, Peer reviewed, 1919–2016	40		1		Nil
British Journal of Nursing	English Language, Peer reviewed, 1919–2016	8		5		Nil
European Journal of Humor Studies	Health, Medicine, Undergraduate, student	24		0		Nil
PhD/Professional doctorate/Masters	Humour, student	4		2		Fontaine 2011
				Total after duplicates removal 9		

3.3 Literature review

The basis of this literature review arose from the eight articles and one PhD chosen, based on the inclusion and exclusion criteria set out.

From the articles obtained, following the critical analysis, five main themes arose: pre-existing capacity for humour, being human, coping, identity building and learning.

3.3.1 Students and their pre-existing capacity for humour

Identifying the student's pre-existing capacity for humour prior to commencement of a healthcare-based programme was illustrated by two of the articles: Rosenberg (1991) and Stein and Reeder (2009).

Rosenberg's study (1991), involving ten American trainee paramedics within a larger study, was designed to explore and contrast this paramedic group's humour use. Utilising a longitudinal design, this group's use of humour was captured through interviews at the beginning and on completion (at nine months) of their paramedic training. One participant did not complete their training. Humour uses within this group were compared and analysed for changes.

Rosenberg (1991) utilised a cross-sectional design, comparing the first group's experience of humour use with that of experienced (1 year and above) paramedics. Rosenberg sought to establish whether the differences were part of adapting or coping methods in response to stress experienced within emergency care.

Rosenberg's sample arose from one location and was representative of the group when reported demographics within the service were considered. Data was elicited via interviews and a content analysis of the interview scripts established similarities and differences between and within the groups.

The study identified the type of humour preferred by the trainee paramedics at the entry to their course as either sexual or ethnic-based in nature. However, this declined towards completion of their training and the prevalence of sick humour, defined in this study as being 'morbid', increased.

Eight participants at the end of their training recognised this change in their pre-existing capacity for humour, not in frequency but in content. Rosenberg attributed

the indoctrination of the trainee paramedic into this type of humour use to be part of the informal socialisation process when working with experienced paramedics. Once their training was completed, only five participants were aware of the changing humour content; however, the “rate of entry”, as coined by Rosenberg (p. 220), in adopting its use was dependent on individual factors. These factors included: previous experience in the emergency service; previous use of humour as a coping strategy; clinical exposure during training; humour environment and current placement role models; and the participant’s own receptivity to acknowledge and participate in the use of this type of humour.

Prior to entry into the paramedic training, eight participants were ready to share their occupational humour with their friends and family whereas the remaining two, who had previous emergency care experience, felt that people would not understand the context of this occupational humour. Experienced paramedics, agreed with the two trainee participants and felt humour could be shared only with those who had similar experiences, highlighting the situational aspect of humour use.

Study participants found it was not only the content of their humour which changed but also with whom they would share this type of humour. In the case of the experienced paramedics, they used humour routinely and generally with their patients. Further discussion regarding the use of this type of humour can be found under sub-section 3.3.3: ‘Students and coping’.

Stein and Reeder’s (2009) study of nine American nursing student novices set out to examine their lived experiences of laughing at themselves. The researcher used face-to-face interviews within a Husserlian phenomenological framework whereby humour is defined under its wider umbrella term to include laughter and its accompanying aspects. One of the authors created a four-column analysis grid to analyse the data. These columns reflect both student and researcher insights coupled with student experiences and, finally, the researchers’ experiences of observed content.

The participants reported being able to laugh at oneself to be an asset when entering a healthcare profession as it equipped them to deal with challenges in their future careers. For all of these participants, maturity and confidence, not chronological age, influenced their ability to laugh at themselves. The majority of the participants in

Stein and Reeder's study felt that humanity was portrayed through being able to laugh at oneself; laughing at oneself was seen as displaying openness to their fellow humans especially, in times of illness. Humanity was perceived as being further portrayed through laughing at oneself since it might reduce stress and help maintain a balanced outlook.

It was felt by all participants that this ability to laugh at themselves equipped them to deal with stressful life events and, for four of them, it forged an attitude in them of not taking things too seriously, which enabled them to move on from the situation.

Stein and Reeder concluded that the potential of being able to laugh at oneself does not prevent things, good or bad, from happening but enables the individuals to take a different perspective, therefore sustaining the balance in both their professional and personal lives.

3.3.2 Being human

Previous studies have echoed one of the themes arising from Stein and Reeder's (2009) study, namely being human. These studies, embedded within nursing practice, focused on humour within clinical nursing education.

Nahas' (1998) study explored 48 Australian student nurses' lived experience of humour as used by their clinical tutors. Her study's definition of humour focused on the clinical tutors ability to produce (initiate and create) humour which elicited positive feelings in the audience (participants) and demonstrated humour appreciation. Nursing students who had experienced clinical practice participated in this study, which used a purposive sample method within a phenomenological approach. Within the student sample, 36 participants were considered to be of Anglo-Celtic background whilst the remaining 12 participants were considered to be of Asian background.

Colaizzi's framework was used to analyse the data elicited from semi-structured interviews. Focusing on the participants' descriptions of shared humorous episodes with their clinical tutors, the participants described the clinical tutors who used humour as "being human" (Nahas, p. 667). For the participants, this was demonstrated in their teachers' willingness to share from their own professional journeys and being able to laugh at themselves, including at areas which the

teachers' required development in. The shared experience of laughing and crying with each other within clinical encounters enabled the students to realise that their teachers felt as vulnerable as themselves when being faced with new and unfamiliar situations within the clinical setting. Additionally, when the students observed the clinical teachers' interactions with others, this allowed them to discern their tutors' genuineness in dealing with others. This theme is discussed later in this review under sub-section 3.3.4: 'Students and identity building'.

Hayden-Mills' (2002) study in the United States also explored the meaning of humour within the student–clinical instructor relationship. Participants, within this hermeneutic-based study, were all females and in their 30s. They were volunteers recruited by the author's colleagues. Elicited data came from unstructured interviews based on the sharing of a humorous experience with a clinical tutor.

The dominant theme found within the participant narratives, as told by Hayden-Miles, was the building of a relationship based on trust between the student and clinical instructor. Central to this was the partnership between the teacher and student, and how humour aided "getting to know each other" as humans because, as adults, the student and clinical tutor worked towards a common goal. In the reciprocity of trust and respect, the student could expect to approach the tutor to discuss mishaps or concerns. In this understanding milieu, the students grew in confidence and self-esteem, and looked forwards towards graduation.

Participants' experiences of clinical teachers that were not humorous resulted in such teachers being likened to dictators. This was when the students feel disempowered and often avoided the clinical instructor to safeguard confidence in their own abilities and self-esteem as they felt the tutor would sanction them if expectations were not met.

3.3.3 Students and coping

The clinical environment for student practitioners is a progressively stressful place due to technical advances, professional and service user expectations, and its unpredictability (Nahas 1998; Hayden-Miles 2002). Fulfilling the daily demands of clinical practice is emotionally strenuous for a registered practitioner, whereas for a student who has the additional expectation of learning, this can be doubly stressful.

A common theme across the chosen articles was the extolling of humour as a positive coping strategy (Rosenberg 1991; Nahas 1998; Parsons et al. 2001; Kaye and Fortune 2002; Wear et al. 2006; Williams 2013).

In the field of social work, Kaye and Fortune (2002) included humour in their definition of habitual coping skills, calling it the emotion-focused activity of coping. They hypothesised the direct positive association between better coping skills, internal motivation, and confidence in one's own ability to perform and a stronger field (placement) performance.

Within this study, 118 American social work students completed a self-reported questionnaire on the following sections: coping, perceptions of learning, perception of skills and demographic information. Most respondents were white females: reportedly typical of their student population.

The main hypothesis was partially upheld in that the authors reported that students with greater habitual coping skills (inclusive of humour) were more likely to have greater confidence in their ability to perform and a decreased perception of task difficulty. In other words, the better one copes, the more confident one is in executing the tasks because they are perceived to be less difficult. So, the authors concluded that a student who copes better has a greater sense of well-being when placed in field placements.

Williams' study (2013), based in the United Kingdom, set out to explore emotional work within the practice of student paramedics. The focus was not humour per se but it was one of the major findings. Using an explorative design, eight student paramedics were recruited and participated in semi-structured interviews. Using thematic analysis, themes were identified.

All eight student paramedic participants highlighted using humour as a channel to dispose of their felt emotions/feelings. This enabled them to deal with distressing, difficult and challenging situations more effectively before moving onto the next call.

These results are comparable with those of Rosenberg's (1991) participants. There was a notable distinction in the use of humour between the groups of paramedics when dealing with occupational stress. Most of the student paramedics identified using humour as a tension-relieving strategy after a busy or bad day, followed by

using it to regain perspective through emotional or cognitive reframing. On completion of their course, humour became an emotional tension-relief, either in the clinical setting or classroom. For the experienced paramedics, however, humour became part of the cognitive and emotional reframing and often was spontaneous in nature. From these findings, Rosenberg suggested that humour functions as a mechanism to allow distance from situations by acting as a coping or defence mechanism, enabling students to gain objectivity and mastery over situations.

In the field of medicine, American medical students participating in Parsons et al. (2001) and Wear et al. (2006) studies justified the use of derogatory humour aimed at patients, by their senior colleagues, as a coping mechanism.

Parsons et al. (2001) focused on how medical students reacted to and interpreted the use of derogatory or cynical humour by their direct seniors within the clinical setting. Thirty-three medical students, with varying clinical rotation experience, were interviewed using a semi-structured interview format. Utilisation of content analysis identified relevant themes. Findings demonstrate that the students, as novices, felt that their non-participatory role in the use of humour towards either patients or other medical students afforded them an etic (outsider) perspective. Narratives also revealed an emic (insider) viewpoint from which the theme of coping arose.

Many of the participants were reluctant to judge their direct seniors' use of this humour-type since they felt they could understand the frustrations associated within clinical practice, with some not ruling out their own use of cynical or derogatory humour. Some examples of perceived frustrations in clinical practice that needed to be coped with were: difficult or ungrateful patients; an ever-increasing workload alongside continual sleep deprivation; unimproved patient outcomes despite considerable medical input; and, finally, assisting in coping with the emotional side of clinical practice, that is, dealing with illness, sadness, grief at death, and having to hurt people when undertaking medical interventions. It is important to note that most of the participants did not find this humour-type appropriate but only accepted its use, especially if most of the patients profited from the seniors' medical knowledge.

This theme continues with Wear et al.'s (2006) study, who acknowledged a well-established phenomenon: medical students become more cynical or display 'ethical erosion' as they progress through their medical education (p. 454). This study

examined how humour, cynical or derogatory in nature, directed at patients is used or perceived by medical students. Across five focus groups, a representative sample of 58 third- and fourth-year medical students participated. Individual analysis of the focus group transcripts by the main authors was followed by common consensus of the main identified themes. Of interest under this section were the reasons for using humour.

The participants understood using derogatory humour as a means of being able to cope with certain situations, for example obese patients who do not improve due to persistent non-compliance or self-neglect, despite the best efforts of the medical team. Another reason cited was emotionally distancing themselves from the patient, as it became easier to deal with the emotional demands of a clinical case than those of a person. Therefore, using this type of humour can be seen as a protective mechanism on an emotional level.

Returning to the discipline of nursing, in Nahas' study (1998) humour use and coping was attributed to managing the workload, as well as making work more interesting, or it was used in order to relieve the stress associated with clinical education.

In her doctoral thesis, Fontaine (2011) used a two-phase qualitative study design. Data was elicited from both a semi-structured qualitative questionnaire and focus groups, involving participants working within a British emergency department (ED). The study aimed to understand different humour types' value and impact within the ED setting. Secondary objectives relevant to the student nurse focus group included exploring their perception of ED culture, the use of humour within it, and investigating if their learning or professional expectations were affected through the use of humour. The questionnaire was distributed to RNs of varying ED experience whilst one of the focus groups included seven second-year student nurses from the local university. The student nurses all completed one acute practice experience. In all cases, this was their first experience in an ED. EDs were described by all participants as being emotionally labile with infrequent release opportunities. The focus groups' themes were divided into appropriate and inappropriate humour categories, but this review reported only the student nurse focus group findings.

The results of Fontaine's study were similar to the findings of Parsons et al. (2001). Fontaine's participants identified a humour subculture within the ED which depended

on the student's 'insider/outsider' status. There was consensus that the students did not feel comfortable expressing their emotions as a result of feeling insecure due to their 'outsider' status in the clinical team. Some junior RNs agreed with the students on this issue. It seemed that they became more accepted into the team as they became more accepting of certain types of humour use within the subculture, often due to increased exposure. For some students, it appeared the RNs became immune to emotionally intense situations due to previous and continuous exposure. Recognising the use of humour as a façade, as a way to suppress, hide, or mask feelings, the students were of the opinion that using humour as a long-term coping strategy does not protect one from the possibility of psychological or emotional burnout.

Within an ED setting, there is an ever-present risk of death or tragedy and those students who had experienced cardiac arrests in the focus group laughed at their recollection of these experiences. Fontaine rationalised that this was due to either pent-up emotion release or an attempt to mask their own feelings of knowledge deficit or inadequacies. Although these participants were upset when staff laughed after unsuccessful resuscitation attempts, the justification was that it was acceptable if the patient was old. Those who had not yet experienced a cardiac arrest disagreed with this justification.

Unanimously throughout these articles, humour has remained a strategy to help student practitioners to cope with the everyday pressures experienced in the clinical environment, in both the academic elements of their programmes and the emotional demands of clinical practice, even if the patient may pay the price.

3.3.4 Students and identity building

On entering a healthcare profession, one embarks on a professional journey from student to registered practitioner. During this time, the student is exposed to the expectations of professional conduct and the aims and qualities aligned to said profession (Merriam-Webster 2016). Through this learning process, associated with professional socialisation, the individual student acquires the attributes required for membership into the professional society (Hammer 2000; Barretti 2004). Hammer (2000) emphasised the significance of professional attitude development as the student becomes socialised into the ideals of their chosen healthcare profession.

Hayden-Miles (2002) explained that student observation of the clinical instructor's behaviours means the student develops an understanding of the role and associated expectations. Nahas (1998) suggested that the clinical tutor's use of humour can enrich the student's socialisation journey as it creates a milieu that demonstrates to the student an environment based on caring and humanistic principles which reflect on patient care.

Due to the transient nature of rotational placements, students enter each new practice experience as newcomers, or are seen as being junior members of the professional hierarchy. Fontaine (2011) suggested that they have an element of vulnerability due to their powerlessness within the clinical setting, as either a newcomer or a student.

On the perspective of powerlessness, Parsons et al. (2001) and Wear et al.'s (2006) studies highlighted participants' feelings that they could not initiate a joke based on cynical/derogatory humour, especially as some consultants felt they should still be idealistic because they were still early in their professional careers. Even though non-initiation of such humour was expected by some seniors, participants sensed there was an expectation of them to appreciate this humour even if they disapproved of it, or else not to voice opinions on its usage. Some participants in Parsons et al.'s study admitted to using cynical/derogatory humour whilst feeling guilty about this since it contradicted their own or professional morals. A common consensus amongst all students was the unacceptability of using humour due to their outsider status within an ED team as they felt it jeopardised other team members' perception of them as learners. Students felt that, as they were being assessed, they should present themselves as being obedient and motivated whilst adhering to the role of the ideal professional. However, Wear et al.'s (2006) participants felt their usage signalled their inclusion into the clinical team and profession. Wear et al. proposed that this is akin to a secret code for insiders whereby students learn where and when to use derogatory humour; however, they must abide by the rules of its usage. Both Parsons et al. (2001) and Wear et al. elucidated a main aspect of this journey: adoption of the professional language. Parsons et al. (p. 544) described it as a "backstage" language for insider use only, thereby creating a private means of communication engendering a sense of belonging and uniqueness. Nahas (1998)

maintained that humour decreases the social distance within the hierarchy through the feeling of being connected, which can, in turn, lead to the feeling of inclusion.

The findings in Parsons et al. (2001) and Wear et al.'s (2006) studies the participants justified the use of cynical/derogatory humour, even assuming its acceptability if a senior member of the medical team initiated its usage. Nevertheless, dissonance occurred for some students between how seniors acted in this manner and yet were expected to be their role models. Findings revealed a growth in the students' demoralisation if the consultants initiated, participated or remained silent when their residents used this type of humour. They struggled with the discrepancy between what was said in front of the patient and was said out of their earshot, which occurred predominantly within theatre. Additionally, in an ED setting, students felt role models using black humour did not meet their professional expectations of a good nurse but also felt that such humour, if used, should be out of earshot of non-emergency personnel (Fontaine 2011). There seemed to be reluctance or unwillingness to judge older and more senior colleagues, and a propensity to conform to their allocated work-colleague's behaviour (Parsons et al. 2001). Fontaine (2011) suggested students' lack of humour use may be linked to their lack of confidence in contravening professionally set standards, which senior ED nurses do daily, often considering it as a must-have characteristic for all ED staff.

Commonalities across the findings lay in students often experiencing a contradiction when comparing the professional ideal with the reality of the clinical environment. Wear et al. (2006) maintained humour is a way of managing these incongruities, especially as the student starts a professional journey full of enthusiasm, with hope and aspirations of achievement, but meets obstacles daily in the form of uncooperative or ungrateful patients, an unpleasant mentor, disillusioned university staff, or unexpected emotional clinical experiences.

Wear et al. (2006) also maintained that students learn their profession through mimicry of role models. Within their study, patients whose illness or disease originated in lifestyle choice (for example, obese patients) were rated as "fair game" to become objects of derogatory humour (p. 455), as they were often blamed for their own condition. Wear et al. suggested that these patients do not present the students with further learning opportunities which makes work routine and

uninteresting, thus they became a source of frustration which justifies the use of cynical/derogatory humour. This application of the superiority theory, according to Wear et al., could arise when status judgements are made about the patients, which are often driven by the students' lack of understanding of the life-chances experienced within different social classes.

These factors can lead to a conflict within the students as they strive towards professional practice yet feel frustrated by their role models' lack of empathy towards patients, or their own lack of empathy. Williams (2013) described emotional labour as the discord between what the student actually feels and what they are expected to feel, and outlined how strategies are required to deal with the emotional demands of caring professions. If students are role modelled into using cynical/derogatory humour aimed at patients (as they can be considered legitimate targets, due to a lack of opportunity because of social status, or suffer negative health outcomes due to recurring lifestyle patterns), then registered practitioners, perceived as role models, must ensure students develop strategies enabling them to cope within a clinical environment, especially as Rosenberg (1991) noted paramedics who did not laugh endured higher rates of burnout.

3.3.5 Students and learning

In the evidence sources chosen, much has been written about the clinical nurse instructors' use of humour and how it empowers the students' learning through the provision of a positive learning environment. Recurrent themes under this section have included the relationship with the clinical tutor and how role models' use of humour affects it.

The individuality of humour and its use in clinical practice, especially in student relationships with their tutors, can either hinder learning, if used at the wrong time, or empower the student to learn freely as the clinical instructor becomes seen as a respected, experienced, knowledgeable nurse (Hayden-Miles 2002; Fontaine 2011). Nahas' (1998) study concluded that clinical teachers with a sense of humour are preferred by most of the student nurses to supervise or facilitate their learning within the clinical area. Hayden-Miles (2002) surmised that humour acts as a conduit to progress students from simply relating to their tutors to entering a relationship in which opposites are seen in a positive manner. This is not new, as Nahas (1998)

already concluded that humour decreases the social distance between student and tutor, making it easier for each to laugh at their own mistakes due to reciprocal respect and understanding. However, Hayden-Miles (2002) offered a new perspective in that students' aspirations of becoming a RN can be obstructed due to the lack of learning when working alongside a stern instructor, regardless of their intentions.

In Fontaine's (2011) study, the participants differentiated between good and bad humour. The participants felt good humour was consistent with a good role model who used humour constructively to enhance their learning. Additionally, good humour was used positively to allay patient anxiety and was appropriate. Using bad/inappropriate humour (which is derogatory and without patient consent) was often seen as incongruent with the students' professional expectations of their role models; it also devalued their learning experience and led to students losing respect for role models.

Humour means different things to different people. Nahas' (1998) study highlighted this: 12 participants of Asian background considered the same piece of humour unprofessional in comparison with 36 colleagues of Anglo-Celtic background. This signifies why using humour must be done with sensitivity and knowledge of cultural influences. She suggested cultural sensitivity when using humour is a factor when deciding what is meant by 'appropriate'. Further criteria have been suggested for who should be off limits for humour: young people or children in crisis, those requiring resuscitation (Fontaine 2011), terminally ill patients, people with cancer and those who have experienced a loss in pregnancy (Wear et al. 2006).

3.3.6 Summary of literature review

In conclusion, from the findings of the studies reviewed here, it would seem that often individuals have a capacity for humour which pre-dates entry into a healthcare profession; however, there is potential for the individual's humour appreciation to change through the socialisation process. Nevertheless, having a capacity for humour offers one the opportunity to cope with the demands of the new environment through achieving a balanced outlook.

Maintaining this balance can contribute to the individual's ability to maintain the focus on their humanity, not only by laughing at themselves but through connecting with others. The shared journey is one key aspect highlighted in this review which enriches the pre-registration students' journey and subsequently their learning experiences. Having to learn in an ever-changing environment is stressful and the ability of humour use to aid with these challenges was prevalent. If humour is used as the only means of coping, especially if derogatory, it could cause additional emotional burden for oneself or others. This means compassion fatigue is a risk, especially if the humour used is aimed at a patient or negative humour becomes the norm simply because senior colleagues use it.

The dissonance experienced by pre-registration students can result not only in additional stress but also in an identity crisis if role models' behaviours are not in accordance with professional and public expectations. Students entering a conflicted clinical setting need to be able to cope with the ever-changing demands made upon them by service users, employers and their professions; therefore, their role models must equip them with the best coping mechanisms possible, of which one is humour. By being role modelled an appropriate use of humour, the students will be able to learn how to utilise it in an environment which is safe and in accordance with professional expectations.

3.4 Summary of the chapter

This chapter presented a comprehensive narrative review of the literature, which identified nine sources of evidence (eight articles and one PhD). The resulting literature review extracted common themes from these sources, using the focus of the research question. This review identified no study within British healthcare settings that concentrates solely on pre-registration healthcare students and their use of humour within the clinical setting.

The previous chapters have framed the backdrop for this thesis regarding what is known about the meaning of humour. There is a gap within the literature around student nurses and their experiences of humour during their clinical placement. The next chapter concentrates on the underpinning theoretical assumptions which influenced the research design of this thesis and its execution.

Chapter 4: The research process

The focus of this chapter is to explore the methodological journey undertaken. It sets out the theoretical assumptions underpinning my research. It then offers the justification for the chosen methodology, Interpretative Phenomenological Analysis (IPA). And, finally, it provides a discussion on reflexivity. First, however, there is a brief comment on this research's background.

4.1 Research background

In chapter two, the multi-dimensionality of humour on an individual, organisational and societal level was identified, and in the literature review (chapter three) the use of humour within the clinical setting by pre-registration students was explored. These highlighted influencing factors on pre-registration students' use of humour within the clinical setting. This led to the research question:

“How do pre-registration nursing students experience the use of humour in the clinical setting (within the United Kingdom)?”

It is necessary to establish which worldview allows the fulfilment of any research question. In order to do this, the theoretical assumptions underpinning one's own position needs to be determined in order to ensure that there is a congruency between the philosophical underpinnings and the research process (Liamputtong 2013).

4.2 Theoretical underpinnings

DeForge and Shaw (2012) explained that this is the first challenge faced by the researcher as paradigmatic worldviews are nebulous. The definition of a paradigm is a worldview with associated philosophical assumptions (Teddie and Tashakkori 2009). Alternatively, Denzin and Lincoln (1998, p. 185) simply defined it as “a basic set of beliefs that guide action” which comprises three elements: ontology, epistemology and methodology. Lincoln et al. (2011) appended axiology to the elements of a paradigm. Durant-Law (2005a) represented these assumptions in the

form of a philosophical trinity based on ontology, epistemology and axiology. It is this pattern which the following discussion will follow.

4.2.1 Discovering my paradigm

For a novice researcher, distinguishing research paradigmatic terminology is difficult as there is no consistency in its interpretation and usage (Goles and Hirscheim 2000).

Denzin and Lincoln (2011) told us that paradigms consist of positivism, post-positivism, critical, interpretative and participatory philosophical positions. Conversely, Crotty (1998, p. 66) named theoretical perspectives which “mean the philosophical stance lying behind the methodology”. Crotty listed positivism, constructionism, interpretivism, critical theory, feminism, postmodernism and others to be theoretical perspectives.

Cohen et al. (2007) simplified the distinction between the paradigms by dividing them into two categories: normative and interpretative. They maintained that the main ideas within the normative paradigm are that human behaviour is governed by rules and associated with a positivist stance, and should therefore be measured with natural science methods.

The positivist approach seeks to reduce social phenomena into generalisable variables which render reality measurable (Sobh and Perry 2006). This is achieved through controlling variables in an environment devoid of context or time (Denzin and Lincoln 1998; Johnson and Onwuegbuzie 2004). Burr (2003) noted that positivists assume our perceptions of what exists are revealed by observation. Positivism purports a value-free approach due to the non-involvement and emotional detachment of the researcher (Johnson and Onwuegbuzie 2004), thus presenting the individual as a “limited humanistic being” (Coyle 2007, p. 15).

The nature of this inquiry is humour, which in itself is a complex phenomenon and can mean several things to the individual; therefore, to reduce it to a single measurable entity, as is the aim of the positivist approach, detracts from the individualised meaning of humour (Sobh and Perry 2006).

Alternatively, the interpretative paradigm concerns itself with the person and their understanding of their experience within their subjective world (Cohen et al. 2007), and is considered anti-positivist. Weaver and Olson (2006) suggested the interpretive paradigm accentuates individual meaning attributed to actions and subsequent understanding. It would allow me, as the researcher, to understand healthcare students' experience and interpretation of humour and to generate insight into their humour behaviour. Andrade (2009) maintained this (interpretative) approach allows a greater insight into the complexity of the lived experience from the perspective of those living it. Walsham (2006) continued that interpretative methods begin with our knowledge of reality, which includes the domain of human action. Topping (2015) explained that within the interpretivist paradigm people's interactions can lead to understanding how we as human beings act within our natural settings and which social processes one engages in, thus making sense of the world. Consequently, my interests lie within the interpretive paradigm. The interpretative paradigm is commonly associated with a qualitative approach (Liamputtong 2013).

4.2.2 My ontological position: critical realism

According to Crotty (1998, p. 10), ontology is "the study of being", which includes asking what the nature of reality is (or simply put, 'how does one see the world?'). Durant-Law (2005b, p. 5) asked the question, "Is there a 'real' world out there that is independent of our knowledge of it?" This is the question I struggled with the most; for me, there is a world out there that I know nothing about and will continue to exist after my passing. I find it hard to give a reality to things I have no experience of so, therefore, I must conclude that my construction of reality comes from my experiences. However, this is only partly true because what has come before us may also shape our realities. When my father was working in the Glasgow shipyards of the 1950s, he was often asked, "Are you a Mick?" (that is, asking whether or not he was of Irish descent, due to the origins of our surname). Being Irish, or of Irish descent, often meant being Catholic, which restricted life opportunities in that context. The reality of being a 'Mick' was discrimination. This was my father's 'real world'. From my stance, there are things in life which can be explained and described and things that can only be lived through oneself, such as living with an illness.

Crotty (1998) acknowledged that the world exists regardless of whether human beings are on it or not. However, he contends that reality *with meaning* emerges when sense is made of it by “meaning-making” beings, leading to a “construction of meaningful reality” (Crotty 1998, p. 10). So, based on the above, I believe there is a reality which exists independently of humans, especially within the natural world. Within the social world there is a reality but it is never whole because each person involved within this reality will have their own perspectives of it. For example, a conversation between two people is a real occurrence, yet if we asked each participant involved to describe what the conversation was about, there would be two different accounts reflecting the perspectives of the participants. These perspectives may be influenced by the individual’s emotions, culture, life experience, biological factors, social factors, gender and age. Consideration of differing perspectives leads me towards critical realism (CR) as an ontological touchpoint.

4.2.2.1 Critical realism

Accepting a critical realist ontology is to accept that a true reality exists even if one is not observing it. I believe there are different perspectives of this reality based on the meaning each individual places on it.

Houston (2010) explained that CR is a stance which posits that the natural and social world consists of real and unseen mechanisms which help shape social events and lives. It also concerns itself with human agency and social structure. Therefore, in order to understand the dynamic and changing social world, one must understand the underlying structures, which rely on social relations. Bhaskar (1998) asserted that within CR there is a layered reality. These layers or domains of reality are: empirical, actual and real. The empirical domain refers to human perspectives of experienced events, that is, events encountered through either the senses, or feelings, which are imperfect. The actual domain refers to events and outcomes that occur in the world but may be unobserved. This regulates the empirical domain (Walsh and Evans 2014). The real domain is concerned with the unseen, taken-for-granted relations and structures or tendencies which generate phenomena, causing events (generative mechanisms) in the actual domain (Bhaskar 1989; Clark et al. 2008; Houston 2010). Critical realists have stated their purpose is to examine the generative mechanisms in the real domain (McEvoy and Richards 2006). Walsh and

Evans (2014, p. e2) applied these stratified layers of reality to uterine contractions as detailed in Table 4.1 below.

Table 4.1: Critical realist layered reality using an application to uterine contractions as an example

Layer of reality	Application to uterine contractions
Empirical	Uterine contraction (effect of Oxytocin, foetal head pressure, gravity) are experienced by the woman and observed by the Midwife who can measure the cervical dilation Healthcare professionals understand this through the physiological manifestations of labour
Actual	“What is known but cannot always be seen” (Walsh and Evans 2014, p. e2)
Real	Those factors facilitating Oxytocin release by reducing adrenaline levels: <ul style="list-style-type: none"> • Adrenaline on a physical level • Environmental effects on adrenaline release (water immersion) • Relational effects (verbal encouragement) • Psychological dimensions (cognitive and affective disposition to flight/fight response)

(Walsh and Evans 2014)

As mentioned in the prologue, I was once placed in a hospital in a black township to fulfil my Midwifery course requirements, despite not speaking the language, and observed how my experiences differed between black- and white-only labour wards. The pattern in Table 4.1 can be repeated here using a humorous event from this time, between me and the registered midwife, to help explain this stratified social reality (Table 4.2 below). Regardless, we were able to find humour within our adversities as highlighted within the earlier literature review.

Table 4.2: Critical realist layered reality using an application to a humorous event

Layer of reality	Application to a humorous event
Empirical	Mirth (emotional feeling) and laughter were experienced by myself and my colleague. Observable by others, for example, through laughter or smiles
Actual	Unobservable stimuli as part/exposure to our common nursing/clinical terminology through the socialisation process into nursing
Real: contains the generative mechanisms which operate to allow us to share the humorous event. This domain is influenced by structure and agency	<p>Factors facilitating humour:</p> <ul style="list-style-type: none"> • Physiological factors (age, gender, cognitive abilities and language processing abilities) • Social factors (differences in first languages and use of colloquiums, ethnicity when based on colour, family role or status, financial status, and professional standing) • Relational effects • Psychological dimensions (how one views humour) • Oppression: formal (whether openly sanctioned segregation and racism through governmental policies such as Apartheid or professional segregation experienced within the white labour ward) • Political influences: historically where one is placed, as Apartheid was a reality for both, but for one it afforded opportunity and the other oppression

With this example, human agency as detailed by Houston (2010) is examined through the social actors' (my black colleague and myself) intentions, motives, choices, meanings and understanding, which are either enabled or constricted by the effects of social structures such as enduring patterns (anti-Catholic sentiment), social rules, norms and laws. Therefore, how people act is not randomly driven by personal desires or needs; rather, it is influenced by the societies in which they live, and their own behaviour within that society that may reinforce or transform themselves (Porter and Ryan 1996).

4.2.3 Epistemology

After ontology, the second part of the philosophical trinity is epistemology. Epistemology concerns itself with what we know and how we know it. Epistemology

is the construction of knowledge by people through the processes of making sense of the world around them: knowledge becomes a social product (Bhaskar 1998). One of Bhaskar's (1998) dimensions of knowledge within CR was that it is transitive: even established facts or models known about the world are built on our perceptions and standpoints, which change in time (Lipscomb 2008; Maxwell 2012). Social reality consists of social forces, structures and human agency (Maxwell 2012). This dimension is ever-changing as it is located within the social and historical context (Bhaskar 1998); for example, the knowledge of humour has been progressive (as illustrated in chapter two), starting with being a body fluid and becoming an umbrella term for many positive human attributes. In order to explain the above, I will use my midwifery example from the prologue.

The humour shared between my black midwifery mentor and me was a co-construction of our definition of humour within the time and place of our experience through our common feeling of being amused, driven by our shared knowledge of nursing/midwifery language, and practices shaped by our understanding of reality. This shared humour crossed several boundaries such as age, ethnicity, culture, language, professional status and Apartheid status. Therefore, I would say knowledge production is a co-construction by those involved within the experience.

This position of CR to which I belong is often adopted by phenomenologists. It has been explained by Finlay and Evans (2009, p. 20) as one which accepts "there is a real observable world but that it is socially constructed". Finlay (2009) placed critical realists in the middle of the knowledge continuum: they, like realists, consider the world to be made of structures where one can measure objects which have a cause and effect relationship (phenomenon can be described and identified) and, like relativists, they take a stance which includes interpretation and diversity of what knowledge means to people (meaning CR can adopt a relativist epistemology). Maxwell (2012) explained critical realists accept that meanings and intentions, although not consciously visible, are part of the world. Lawthorn and Tindall (2011, p. 17) summarised the critical realist position as "maintaining a central focus on the ways in which people make meaning of their experiences whilst being aware of the influences that broader social structures have on these meanings".

Crotty (1998) called attention to the fact there are different interpretations of the same phenomenon dependent on place and time, thus producing varying types of knowledge (which he describes as “sets of meanings”, p. 64) within different realities. Additionally, Rizwan (2014) expressed that one’s epistemological position evolves from one’s own history and values. These points I agree with as my own experiences in South Africa were different to those of my Midwifery colleagues, hence the idea of multiple realities.

Crotty (1998) maintained objectivity and subjectivity are at the centre of epistemology, and Mayoh et al. (2012) described this in terms of the researcher–participant relationship. Objectivity is obtained when the researcher and participant are deemed to be independent from each other, as often seen in quantitative inquiry, whereas subjectivity is when the participant and researcher are interdependent, which places the researcher within the qualitative research process. I do believe that I, as the researcher, am an integral part of this process alongside the participants.

4.2.4 Axiology

The final part of the philosophical trinity is axiology, which deals with values and ethics. Lincoln et al. (2011) described how values are woven through the research process and, as highlighted by Teddie and Tashakkori (2009), are often associated with the researcher’s stance or personal values. From my perspective, no research can be value-free as there is always a human element involved that ultimately influences the research question and design.

Concurring with Durant-Law (2005b), I believe knowledge should be used to enable positive change or to inform, which is why I want to give voice to the students regarding their experience of humour, given the paucity studies of this kind in the UK.

4.2.5 Conclusion of theoretical underpinnings

To conclude, my belief system is:

- A reality exists outside of human consciousness, but the known reality can only ever be partly known as each individual will have their own perspective of it

- When we experience something as being humorous, without understanding the underpinning ever-changing driving forces, the experience is co-constructed within the dialogue between those involved
- What we discover should be used for good and each person's voice is equal in its validity of opinion.

4.3 Methodology of choice

Kramer-Kile (2012) explained multiple connotations of the word 'methodology' can lead to confusion for the novice researcher. Methodology is defined by Crotty (1998, p. 7) as "a plan of action" or, as Denzin and Lincoln (1998) suggested, it is how the knowledge of the world is gained. This study adopts the definition of methodology proposed by Teddie and Tashakkori (2011, p. 339):

a broad approach to scientific inquiry specifying how research questions should be asked and answered. This includes worldview considerations, general preferences for design, sampling logic, data collection and analytical strategies, guidelines for making inferences, and the criteria for assessing and improving quality.

Durant-Law (2005a) maintained that a researcher, by establishing their philosophical trinity together with the research paradigm, can establish the appropriate methodology and philosophical alignment. Alternatively, Finlay and Evans (2009) maintained it is philosophy plus methods which constitutes the methodology. As my interests lie within the interpretive paradigm and my ontological stance is underpinned by the CR stance – which accepts the need to understand meaning (Maxwell 2012) and how people make sense of their experiences – a qualitative methodology was best suited to fulfilling this study's research question. Liamputtong (2013) illustrated qualitative approaches offer the flexibility and fluidity required when the focus of the research is on meaning and interpretation; she maintained these capture the lived experience of the people from their own perspective.

Qualitative approaches contemplated include grounded theory (GT) and phenomenology. Creswell (1998) explained GT uses heterogeneous sampling with the objective of developing theories. Discounting this approach occurred because not many studies involving a specific focus on healthcare students' experience of humour exist, so many areas require further investigation before considering theory

generation. Further reasons are that this study is concerned with giving a voice to healthcare students regarding their experience, and finally the constraints of time , as Bryman (2012) emphasised a good quality GT study requires time, which within a professional doctorate may not be achievable. Phenomenology, as a methodology, “seeks to understand, describe and interpret human behaviour and the meaning individuals make of their experience” (Liamputtong 2013, p. 459). Crotty (1996) alluded to the complexity within the phenomenology field due to the intricacies of the approaches; this can confuse the researcher, leading to the questionability of their findings.

Considering the main driver of this thesis is the individual’s lived experience of humour, it seemed appropriate to choose phenomenology since it would enable people to make sense of their world. This would allow participants an opportunity to describe and understand their humour use within their everydayness (the clinical setting), the meaning they give to humour (depending on personal filters, life experiences and the present context) and how their experiences of humour use influence their everydayness.

4.3.1 Phenomenology and its contributors

Mayoh and Onwuegbuzie (2015) explained that phenomenology can be considered either as a philosophy or as a methodology. Either way, its main focus is on the individual’s experience and their interpretation of it (Brocki and Wearden 2005; Smith et al. 2009). This approach seems plausible as both spontaneous humour and a student’s professional journey belong in everydayness. Langdridge (2007) commented further that the focus is to understand lived experience by connecting immediately and directly with the world as we experience it. Finlay (2011, p. 16) continued that the focus is on the “embodied lived experience and the meaning held about that experience” with the aim of describing phenomenon through our everyday experiences. Van Manen (2014) emphasised that topics for phenomenological inquiry can arise from every human experience possible (he provides examples of inquiry, such as an incident, thought or feeling) as phenomenology concerns itself with the meaning arising from these experiences. There are two main types of phenomenology: descriptive (Husserl) and interpretative (Heidegger and Gadamer) (Sloan and Bowe 2014).

4.3.1.1 Husserl's descriptive phenomenology

Phenomenology rose to prominence with Husserl's declaration "*zurück zu den Sachen selbst*" – "Back to things themselves" – and his discussion on the essence of conscious experience, which brought the focus of the lived experience back into prominence (Finlay 2009a; Smith et al. 2009). Husserl supported the notion of *Lebenswelt* (lifeworld) because it is comprised of "a world of objects around us as we perceive them and our experience of our self, body and relationships" (Finlay 2011, p. 1). Koch (1995) explained the lifeworld is not usually accessible due to the taken-for-grantedness of experiences. The role of everydayness is evident in the adoption of natural attitudes, which are our everyday assumptions about our world (Finlay and Evans 2009). Van Manen (1997, p. 9) maintained this is the "pre-reflexive, pre-theoretical attitude", which according to Finlay (2009b) means experiences happen before being thought about or talked about. Lavery (2003) described how one experiences one's lifeworld pre-reflectively, without categorising or analysing it.

Furthermore, Husserl advocated *epoché*, a series of reductions through the *bracketing* of one's own knowledge of the phenomenon, culture, history and context (Eatough and Smith 2008), as all perceptions are influenced by the perceiver in the form of subject and object, which cannot be separated (Moran 2000). Therefore, by bracketing one can concentrate on the phenomenon under study, rather than one's assumptions.

The aim of Husserl's phenomenology is to provide a universal description of the essence/structure of the phenomenon as arising from the participant's lived experience through the researcher's philosophical reduction (Dowling 2007; Converse 2012; Tuffour 2017). With this in mind, I discounted this type of phenomenology as it could not provide a means of exploring the students' experiences of humour and what it meant to them. Additionally, I felt, as the researcher, I am part of the process and would find it difficult to discount my own lived experience, both as a student nurse and RN.

4.3.1.2 Interpretative phenomenology (hermeneutics and existentialism)

This section focuses on Heideggerian phenomenology. Heidegger, a protégé of Husserl, developed his phenomenology to be one of understanding and interpretation (Geanellos 1998), as humans are able to find meaning and

significance in their lives (Draucker 1999). Heidegger redirected phenomenology from people or phenomena to exploring the lived experience (*Dasein*) by looking for the meanings embedded within it; in this way it moves beyond Husserl's description of concepts and essences (Flood 2010).

Dasein, as "the situated meaning of a human in the world" (Annells 1996, p. 706), highlights another distinctive difference of Heidegger's phenomenology: an emphasis on the person being embedded within their lifeworld/human experience as it is lived (Dowling 2007). Lavery (2003) explained that for Heidegger understanding was a basic form of human existence and interpretation was vital to this process of understanding; however, the interpretation is influenced by our background. This highlights the relevance of context and perspective: individuals' understanding does not occur in isolation of their culture or historicity (Geanellos 1998; Draucker 1999). Therefore, the sense one makes of one's world comes from within, not from a detached viewpoint.

Geanellos (1998, p. 155) defined interpretation as "an attempt to grasp or recreate meaning in order that more complete or different understandings occur, it seeks to make clear that which is fragmentary or hidden". Lavery (2003) maintained meaning is found in the co-construction between oneself and the world, so as one is constructed by the world one simultaneously constructs the world from one's background and experiences. Koch (1995) explained this as the concept of co-constitutionality, which emphasizes the unity between the person and the world.

Heidegger believed one cannot discard one's previous experiences of the world (Sloan and Bowe 2014), which is a clear departure from Husserl's bracketing. Converse (2012) highlighted that, in order to begin understanding/interpreting, one needs to know one's pre-conceptions; this is especially pertinent in the research context. Geanellos (1998) and Draucker (1999) clarified Heidegger's concept of fore-structures of understanding as being closely linked to how one understands the world and how one interprets reality. Wojnar and Swanson (2014, p. 174) provided an explanation of fore-structures, consisting of three concepts: fore-having ("individuals come to a situation with background practices from the lifeworld which makes interpretation possible"), fore-sight ("socio-cultural background gives a point of view from which to make an interpretation") and fore-conception ("the meaning

and organisation of a culture-language and practice – which are already in the world before we understand”) (Koch 1995, p. 831). Therefore, as a researcher one must be cognisant of one’s own fore-structures and how these may influence the interpretation of the data.

It is helpful here to consider the hermeneutic circle: a circle of understanding and interpreting the whole text\experience through the examination of the parts of the text\experience, and vice versa (interpreting the parts through the whole) in relation to the cultural and historical context. It is through this circle that one begins to interpret and understand the lived experience, as Heidegger (1962, p. 153):

In the [hermeneutic] circle, is hidden a positive possibility of the most primordial kind of knowing

Finlay (2011) stated it is the “being of something” that one begins to understand by moving back and forth through all the parts. Although engagement through the circle is considered never-ending, one must recognise, on entering the circle, that one’s preconceptions are influenced by one’s own experience and expertise on the topic. This limited outlook is called one’s horizon. Recognising one’s own horizon is imperative because the researcher, as the interpreter, must maintain openness to the participant’s textual voice and so new understanding is reached (Eatough 2009). This enables the researcher to be open to the unexpected (Hefferon and Gil-Rodriguez 2015). The hermeneutic circle is further discussed in the following section, 4.3.2.

Table 4.3 below is a summary of the differences between descriptive and interpretative phenomenology.

Table 4.3: Key differences between descriptive and interpretative phenomenology

	Descriptive phenomenology	Interpretative phenomenology
Emphasis	Describes universal essences	Understanding the phenomena in context
View of a person	Is representative of the world he/she lives in Mechanistic view of a person	Is a self-interpreting being
Belief underpinning	Consciousness is what human share	Contexts of culture, practice and language are what humans share
Previous knowledge	The aim is to present a researcher-free description of the phenomena through self-reflection and stripping of previous knowledge	Active co-creation of the interpretations of the phenomena, by the researcher
Context	Peripheral importance	Central importance
Quality	Adherence to established scientific rigour	Need to establish contextual criteria for trustworthiness of co-created interpretations.
Reflection	Bracketing guarantees interpretation is free from bias	Understanding and co-creation by the researcher and the participants are what makes interpretations meaningful through the use of the hermeneutic circle.
Person	Mind-body person lives in a world of objects	Person exists as 'being' in the world
Meaning	Meaning is unsullied by the interpreter's own normative goals or view of the world	Interpreters participate in making data
Data	Participants' meanings are reconstituted in interpretative work by insisting that data speak for themselves	Within the fore-structure of understanding interpretation can only make explicit what is already understood

(Koch 1995, p. 832; Lavery 2003, p. 32; Wojnar and Swanson 2014, p. 176)

Initially, it seemed to me a Heideggerian approach was best suited to this study's aims. His focus on experiences for themselves and on everydayness (activities and relationships people are involved in) which enables the world to appear to us and be meaningful for us (Smith et al. 2009). This links to the everyday experiences of the student nurses within the clinical setting and what humour means to them. Additionally, his focus on the interpretation of meaning, on the co-constructed data which draws on the expertise of the researcher, within ordinary everydayness (van Manen 2014). However, through reading I discovered his long term association with the *Nationalsozialistische Deutsche Arbeiterpartei* (NSDAP), the 'Nazi party' (Converse 2012). Langdrige (2007) suggested one should bracket Heidegger's actions and not disregard his contributions to the philosophy of phenomenology. However, adopting a purist approach (based on one philosophy) was never an

option for me due to my previous experiences of what 'purism', whether political or professional, can do and how it oppresses people, as detailed in the prologue.

Therefore, other phenomenological approaches were considered; Interpretative Phenomenological Analysis (IPA) was an option. IPA is built on three main theoretical cornerstones: phenomenology, hermeneutics and idiography (Smith and Eatough 2007; Smith et al. 2009).

4.3.2 Interpretative Phenomenological Analysis

IPA is a methodology, developed and introduced by Jonathan Smith, that is concerned with the individual's life experience and how sense is made of this experience (Eatough and Smith 2008). Several authors have explained that at the core of IPA is the meaning of the lived experience to the participant and how, through personal perception and reflection within their personal and social lifeworld (as a meaning-maker), certain phenomenon are experienced (Reid et al. 2005; Langdridge 2007; Smith et al. 2009; Finlay 2011).

The phenomenological aim of IPA is the exploration of experience in its own terms. Smith et al. (2009) suggested it is the particular significance of everyday lived experiences which are of most interest to IPA. From a theoretical basis, IPA celebrates Husserl's contributions towards phenomenology, which highlighted the significance and relevance of experience and its perception, but it claims to have more modest ambitions to "capture particular experiences as experienced for particular people" (Smith et al. 2009, p. 16). Phenomenologists further credited with underpinning the development of IPA are Heidegger, Gadamer, Schleiermacher, Merleau-Ponty and Sartre, all of whom Smith et al. mentioned as explaining the complexities of understanding 'experience', which includes it being lived and the uniqueness of a person's embodied and situated relationship with the world with ever-developing perspectives and meanings. Smith et al. continued to explain that, due to the significance of the experience, people will engage in reflecting, thinking and feeling as they decide what the experience means to them. Therefore, humans as sense-makers will be able to provide an account of their sense-making of these experiences through the medium of language; however, accessing the experience relies on what details the person shares (Smith et al. 2009).

Smith et al. (2009) described the intertwining of phenomenology and hermeneutics in IPA: being phenomenological is getting as close as possible to the participant's experience, with interpretation (hermeneutics) between the researcher and participant resulting in the phenomenon being seen. Smith et al. have drawn upon the works of Heidegger, Schleiermacher and Gadamer to explain the hermeneutic underpinnings of IPA, and how their influences have developed IPA as a form of interpretative phenomenology. Tuffour (2017) explained these three phenomenological authors offered the basis of the argument of the inescapability of the historicity of understanding: humans are embedded in the lifeworld of language and relationships. This highlights Heidegger's core notions of lived time and place (Craig 2017).

Heidegger's contribution to IPA has been arguing for the necessity of realising the researcher brings their own pre-suppositions (prior experiences, assumptions, preconceptions) to the interpretation. Heidegger's notion of the hermeneutic circle that never closes enables further questions to be asked to advance our understanding; Wilson (2014, p. 30) called this a circle of "understanding and interpretation". Smith et al.'s (2009, p. 35) explanation of the whole and part of the hermeneutic circle within the research process stated that the "whole is the researcher's biography and the part is the encounter with a new participant". Participant and researcher each enter the interview process with a pre-understanding of the topic, and it is through the questions posed that the researcher accesses the participant's *Dasein*. The pre-understandings meeting in a spiral motion leads to new discoveries for both participant and researcher (Moran 2000). This is an iterative process (Smith et al. 2009). Byrne (2001) suggested that an underpinning assumption associated with hermeneutics is that humans experience the world through language, which provides both understanding and knowledge.

It was Gadamer who prioritised language, as this is the one and only medium through which phenomena can appear and be understood (Moran 2000). In order to understand, one must engage with the text produced through the interview process by the researcher and participant.

Finlay (2003, p. 107) best encapsulated the hermeneuticists' argument in the following quote: "our embeddedness in the world of language, ideas and social

relationships and [...] the inescapable historicity of all understanding". This, for me, brings forth the aspects of a lifeworld that are important: lived temporality, lived corporeality, lived relationality and lived spatiality.

Smith and Osborn (2007) emphasised Heidegger's (2010) concern with one's presuppositions obstructing the interpretation of the data corpus, and Heidegger's (2010, p. 195) proposal that "priority should be given to the new object rather than to one's preconceptions". They further highlighted Heidegger's idea that, as one is embedded in the world and cannot suspend one's beliefs or values, engaging in reflexive process, rather than bracketing, would assist the researcher be aware of their influence on the analysis and wider research process. One way of incorporating this idea would be the adoption of a phenomenological attitude to the data corpus (Hefferon and Gil-Rodriguez 2015). Finlay (2011) presented this as the researcher maintaining a curious, open and non-judgemental approach to the participant's stories/data whilst concurrently being aware of their own pre-understanding's potential to intrude on the analysis. For the wider research process, engaging a reflexive approach was my preference so that I could be aware of any decision made during this study's execution, and the potential influences. The discussion on reflexivity can be found later in this chapter (section 4.4).

Anstey (2012) described IPA as having a double action of uncovering and interpreting meaning, which derives from Heidegger's premise of examining the appearance of the phenomenon as it can be visible or concealed. This applies to humour, as detailed across chapters two and three, as I would consider it to be often a taken-for-granted phenomenon: people accept humour as being part of their everydayness and yet its function often conceals a deeper intention.

Smith et al. (2009) described the double hermeneutic whereby the researcher is trying to make sense of the experiencer making sense of their experience. A researcher must simultaneously utilise their human abilities (mental and personal) whilst being required to work more self-consciously and systematically, and accept that the interpreted account is second order (Polkinghorne 2005). This means the researcher's sense-making is based on access to the experience via their participant's detailed account (Smith et al. 2009). As IPA acknowledges, the role of the researcher is to offer an alternative narrative through their sense-making of the

participant's account, drawing on their own interpretative resources (Smith and Osborn 2003; Eatough and Smith 2008). One must accept that a value-free interpretation of the participant's world is unlikely (Smith et al. 2009). The second double hermeneutic, Smith et al. (2009) illustrated as one of empathy and questioning, which lead to understanding through making sense of what it is like for the participant and "illuminating and making sense of something" (p. 36). This means approaching the data analysis with both a questioning and empathetic stance.

Smith et al. (2009) maintained IPA is committed to the particular by exploring what the experience is like for that particular person and what sense they make of it. Utilising Smith et al.'s (2009) explanation of IPA's aim, this study focused on capturing particular uses of humour as experienced by particular people, namely student nurses in a particular context: clinical practice in the UK. Both Reid et al. (2005) and Pringle et al. (2011) stated how IPA enables the analytical account to be produced by both the participant's and researcher's reflection due to the researcher explicitly entering into the research process through the subjective and reflective process of interpretation (Brocki and Wearden 2005).

Smith (1996) asserted that another underpinning tenet of IPA is symbolic interactionism, which states that an individual's ascribed meaning of the event can only be accessed through interpretation, hence the importance of the researcher's role.

IPA as a methodology was suited to this study as it has the potential to explore people's experiences and meanings of humour, which I consider to be an often taken-for-granted human phenomenon in people's everydayness. IPA having three components enabled me to draw on the strength of each to begin to build a holistic picture of student nurses' experiences of humour use within the UK clinical setting. Idiography brought out the individuality of humour and the particular journey each nursing student had embarked upon influenced by their allocated placements throughout their programmes. Additionally, presenting divergent (individual) and convergent (shared) themes allowed the individual to have a voice within this study (Smith et al. 2009). Phenomenology highlighted the embedded nature of the individual within the context of their everydayness (influenced by their background – social, political and cultural) and its subsequent influences on their use of humour

and what it means to them. Hermeneutics elucidated the role that I, as the researcher, play in the interpretative process and the need to be aware of my own preconceptions. When I was writing the prologue to this thesis I began to discover why and how much humour is important to me within my own particular situation, and what underlying influences were in my personal and professional lives. Additionally, according to Wojnar and Swanson (2014), the co-constitutionality between me, the researcher (looking for the meaning within the narratives that is invisible to the participant, Lopez and Willis 2004), and the participant involves a circular process of interaction and interpretation that co-creates a new understanding of humour from the student nurse's perspective within UK clinical settings.

In summary, the threefold aim of IPA is:

1) Conducting a detailed exploration of a person's personal perception and ascribed meaning of a lived experience or phenomenon under investigation within their lifeworld (Smith et al. 1999; Smith and Osborn 2007; Smith 2011a). Smith and Eatough (2012, p. 442) explained that IPA concerns itself with "unravelling the relationship between what people think (cognition), say (account) and do (behaviour)". As people make sense of their personal and social lifeworld, Smith and Eatough (2012) suggested the main focus of IPA is the meanings participants hold of particular objects, events and experiences.

2) Being interpretative: emphasising the active role the researcher plays within this dynamic research process in accessing the participant's lifeworld (through their dialogue, as there is no direct access to the participant's experience), which is potentially complicated by the researcher's own preconceptions. A two-stage interpretation process (double hermeneutic) occurs: the researcher attempts to make sense of the participants trying to make sense of the lived experience for themselves (Smith 1996; Smith et al. 1997; Smith et al. 2009, p. 3). In other words, the researcher attempts to obtain an insider perspective from the participant's narrative whilst stepping backwards to obtain an outsider view through critical questioning (Smith and Eatough 2007).

3) Being committed to the particular through an idiographic approach: attending to convergent (shared) and divergent (individual) themes (Smith et al. 1997; Smith et al. 2009; Smith 2011a). Larkin et al. (2006, p. 103) explained IPA studies can draw

on both meanings of the word ‘idiography’ (on an individual level and study of specific event or situation), as this study has done, exploring particular individuals at a specific time in their lives in a particular situation. Finlay (2011, p. 140) described this approach as an “idiographic sensibility” whereby the emphasis is on how a particular phenomenon (here, humour) is understood by particular people (here, student nurses) in a particular context (here, UK clinical settings) (Smith et al. 2009).

4.3.2.1 Strengths and challenges of using Interpretative Phenomenological Analysis

The strengths of IPA include providing the novice researcher a framework for a three-stage analysis and moving the interpretation beyond description, helping to capture the meaning for the participant embedded within the experience. The narrative account has produced a richness and depth of understanding of what the student thinks and feels about humour. Due to the experiential and individual nature of the phenomenon, humour, the participants are considered experts (Smith et al. 2009; Shinebourne 2011). The approach of studying a shared, whilst still often unique, experience across a small group of people can be considered an additional strength (Wagstaff and Williams 2014).

The limitations of IPA can include the fact that access to a participant’s world is dependent on that participant’s ability to articulate their experiences (Brocki and Wearden 2006). As interpretation occurs via the researcher’s interpretative activity, bias can occur if the researcher does not adopt a reflexive stance. By being reflexive, the researcher can identify their own fore-conceptions or current “horizon of understanding” (Moran 2000). Another point of consideration is the time required to complete the transcription and detailed analysis within an allocated timeframe (Smith et al. 2009).

4.3.2.2 Critique of IPA

IPA is not without its critics. Langdridge (2007) and van Manen (2017) both questioned its phenomenological base due to the assumption that IPA is concerned with cognition. Tuffour (2017) detailed how, for some, phenomenology and cognition are incompatible. Smith et al. (2009) addressed this assumption by suggesting cognition is required for sense-making and meaning-making activities as it is an aspect of one’s being-in-the-world.

Paley (2017) questioned Smith et al.'s (2009) claim that meaning is resident in the data and the analysis (first steps) are external-theory free. He suggested there is an overwhelming focus on 'identity' within IPA studies, concluding that "interpretation is only possible with a background theory" (p. 148) and there is no method in IPA. In his book, *Phenomenology as qualitative research: a critical analysis of meaning*, he offered few, if any, compliments to other phenomenological approaches (van Manen's hermeneutic approach and Giorgi's modified Husserlian approach) on their methods. Due to my limited knowledge of the philosophical claims amongst contemporary phenomenologists, I, as a novice researcher, felt using IPA's steps of interpretation gave me structure to format my data analysis, which was driven by the text in front of me. I delayed writing my literature review so that during the interviews my formal knowledge of student nurses' experiences of humour was minimal. I also wrote a prologue of my own experiences of humour as a student nurse. Therefore, I would say I did not look for 'identity' with the text, in contrast to Paley's critique to IPA.

4.4 Reflexivity within this study

The variety of definitions of reflexivity suggests there is no consensus as to what it is and its purpose; however, there has been overwhelming agreement to the tenets within it (Darawsheh 2014). One common theme is the need through critical self-awareness to explore one's own assumptions, feelings, perceptions and personal values and how these can impact on all stages of the research process (Kingdon 2005; Lipp 2007; Walker et al. 2013; Johnston et al. 2015). Finlay (2009) highlighted that one is only reflexive of what one is conscious of, with specific attention to potential dilemmas in morals, ethics and power dynamics within the research relationships, and Probst (2015) maintained it is only possible to a certain level. Dowling (2006) highlighted the significance of reflexivity within the research process as the researcher's preconceptions cannot be suspended (Converse 2012).

Darawsheh (2014) emphasised that, whether reflexivity is used as a tool of research or to curb bias and subjectivity on the researcher's part, it allows for the awareness between two subjective viewpoints to ensure I, as the researcher, truly interpret what the students really meant. McCabe and Homes (2009) suggested the researcher must be aware of bias within one's research study coming from prior knowledge and

experience of the phenomenon. Dowling (2006) identified two types of reflexivity: personal and epistemological.

Personal reflexivity has been described as self-reflection and consideration of the influences (individual identity, biography and interests) the researcher brings to the study (Tomkins and Eatough 2010). Finlay (2002) maintained reflection and reflexivity lie along a continuum and should be an active processes, thus enabling one to challenge taken-for-granted ideas, values or beliefs (Dowling 2006). My personal critical self-reflection began as a written (later audiotaped) journal in which I recorded my thoughts on what humour meant to me through to the feelings I felt towards each of my participants and beyond. Within my chosen methodology my voice within the process has been acknowledged; however, being over-reflexive can shift the focus from the student participants to me, thus compromising the study. I sought to avoid this by engaging in critical reflexive discussions with my supervisors.

Epistemological reflexivity relates to Gadamerian hermeneutics. It compares reflexivity to the hermeneutic circle as individuals/researchers can engage reflexively with “concepts or emotional information stored in memory or in-the-moment experiences” (Dowling 2006, p 12). McCabe and Holmes (2009, p. 1522) extended this further by highlighting that reflexivity

is the practice of being cognizant of one’s views and social position and of the effect that these may have on the research and those being researched.

Johnston et al. (2015) pointed out further tensions within this process exist due to the researcher’s need to balance being in familiar environments with the notion of strangeness and how much self-disclosure to partake in, as detailed by Probst (2015). Being a researcher within one’s own area of expertise uncovered a problem, familiarity, as one has pre-understanding of the field. One aspect of familiarity is positionality: researchers are often part of the social group being studied (Bonner and Tolhurst 2002). Moore (2012) defined insiders as individuals who have a place in the group, based on gender, race or ethnicity; therefore, the insider has a “lived familiarity with the group” (Mercer 2007, p. 2). Being an insider creates distinct advantages for the researcher because being seen as one of the group makes it easier to gain acceptance, which guarantees quicker access into the participant’s

world. Another advantage is that one associates with the culture and jargon (Kanuha 2000; Bonner and Tolhurst 2002).

Personal stories and examples within the participants' accounts evidenced their acceptance that I had knowledge of their nursing world, as indicated either through shared laughter, unfinished sentences, use of nursing terminology or discourse markers such as "you know" (Laserna et al. 2014). Hayfield and Huxley (2015) stated the familiarity of being an insider can enable one to gain richer interpretations or a deeper sense of the shared context.

However, having an insider view of the participants' world of nursing can be fraught with disadvantages, such as being seen as a healthcare professional rather than as a researcher (Holloway and Todres 2010). Knowing other disadvantages is paramount as it prevents prejudice (either in the data collection or analysis), which can occur as the researcher is part of the research process. Some disadvantages applicable within this research project include: interpretation bias (Mercer 2007); participants focus on dramatic events only (Baillie 1995; Kanuha 2000; Allen 2004); participant choice bias – only choosing those with whom the researcher feels comfortable (Bonner and Tolhurst 2002); and participants may fear they are being judged (Reid 1991; van der Geest and Sarkodie 1998; Mannay 2010). Kanuha (2000) raised an interesting point that participants' vague statements may not be investigated due to certain assumptions made by the researcher.

As one can simultaneously be an insider and an outsider, I sought to identify commonalities between myself and my participants. Naively, in the beginning, I thought I could identify with the participants as I too was once a student nurse; however, I was a diploma student nurse in the 1980s in an African country under Apartheid policies. These students were being educated to degree level within a western European country. Therefore, I concluded few, if any, commonalities were shared with the participants, confirmed with a retrospective glance at Table 5.2 however, all had relational experience within the ward environment, which was part of this study's setting.

The setting of this study (clinical setting) was the place of commonality and familiarity between the researcher and the participants. The familiarity within this study would be the study's setting. Mannay (2010) maintained that, when one works on familiar

territory, the findings can be overshadowed by taken-for-granted assumptions because routines become familiar, as detailed by Creswell (2013). Hammersley and Atkinson (2007) explained this over-familiarisation can limit and distort data. Delamont et al. (2010, p. 3) discussed strategies to fight familiarity, or to “make the familiar strange”. The strategy applicable within this study was to take the viewpoint of the less common group, student nurses, as much of the humour literature within the setting focuses on either patients or registered staff. Delamont et al. continued that to fight familiarity one needs “self-conscious strategies” (p. 5), which I achieved through discussing data collection within the supervisory process and seeking critical friends from other disciplines to provide feedback on certain steps within the research process. Another strategy was specifically seeking transparency in the process through the use of reflexivity (discussed in section 5.10.3).

Interviewing different participants led me to adopt various versions of the insider/outsider dichotomy; for example, sometimes I was a teacher (outsider), another time a fellow African (insider). Holloway and Todres (2010) supported my ever-changing outsider/insider role; however, this simple outsider/insider dichotomy representation is challenged by others (Hammersley and Atkinson 2007; Simmons 2007). Adler and Adler (1994) and Mercer (2007) maintained the researcher adopts ever-changing roles, either as an insider or outsider, due to the multiplicity of realities within the study setting (Hammersley and Atkinson 2007); the group or individual participants the researcher is currently engaging with (Allen 2004); and the time, location and topic (Mercer 2007).

Hayfield and Huxley (2015) described the outsider/insider dichotomy as impacting directly on the co-constituted knowledge, the meaning of which (as a product of the research relationship) is negotiated between the researcher and participants within a particular social context, as asserted by Finlay (2002). This resonates with knowledge creation from a critical realist perspective as there is acceptance that knowledge stems from human social practices and is located in a historical and social context (Mingers 2011).

Returning to reflexivity, authors have identified challenges within the reflexive process, such as time – any temporal constraints potentially impede deeper self-awareness as tension in meeting deadlines may occur (Lipp 2007; Probst 2015).

Reflexivity can leave the researcher feeling vulnerable as one may be exposing hidden fears and biases, hence the need for space and engagement (Johnston et al. 2015; Probst 2015). This was the case when I began to write the prologue as the flashbacks to my childhood traumas and the intensity of the feelings experienced surprised me as I began to deconstruct my own humour history and the role those experiences played in this journey.

Probst's (2015) enquiry into the nature of reflexivity and whether it is 'done right' highlighted the ambiguity of the reflexive process and how there is no agreed correct course of action. Findings from Probst's enquiry have highlighted the lack of training or clear guidelines available, especially to novice researchers, to quell self-doubt about the adequacy of one's reflexivity. Dowling (2006) emphasised it is not for one to conduct a lone introspection but rather to create a tension between one being both the object and subject. She suggested using the supervisory relationship or critical friends to challenge the researcher as these assumptions can influence both data findings and interpretation.

Unanimous support for researcher reflexivity within a research project has been expressed through the perceived benefits, because when being transparent, which increases rigour and trustworthiness of the study, limitations become apparent (Kingdon 2005; Lipp 2007; Walker et al. 2013; Darawsheh 2014; Johnston et al. 2015; Probst 2015). Yardley (2000) explained that conventional criteria for assessing a study's quality, such as reliability and replicability, are not permissible when dealing in studies investigating people's experiences. Therefore, she proposed the following criteria: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. These are discussed in chapter five.

4.5 Conclusion

This chapter set out the research background and the theoretical underpinnings of the study based on my experiences of Apartheid. It worked its way through the phenomenological field and offered justification for using IPA to explore student nurses' experiences of humour use within the UK clinical setting. Strengths, limitations and criticisms of IPA were presented. Finally, a discussion on reflexivity, researcher positioning and limitations concluded this chapter.

Chapter 5: Research Methods and Data Analysis

The focus of this chapter is the exploration of the steps undertaken within the study's research process. The execution of the study design is described and critiqued with underpinning literature; ethical approval, data storage, sampling techniques, data collection method, data transcription, quality measures and the data analysis undertaken supported by relevant literature are considered, explained and justified. The interviews were analysed using IPA, which enabled the researcher to make sense of the participants' own sense making of their experience of humour use within the clinic setting. This is followed by the development of the superordinate themes. The third order analysis acknowledges the role of the researcher within the research process.

5.1 The research process steps

Gerrish (2015, p. 3) explained "research is concerned with generating new knowledge through a process of scientific enquiry, the research process". The research process consists of several steps which consistently require informed decisions by the researcher. Generally, the steps within the research process are: developing the research question, searching the literature landscape, choosing the methodology and design, generating a research proposal, gaining ethical approval, determining the data collection method, analysing the data and presenting the study's results. This chapter deals with the ethics, data collection method and the data analysis steps.

Figure 5.1 (below) illustrates the research process steps for this study.

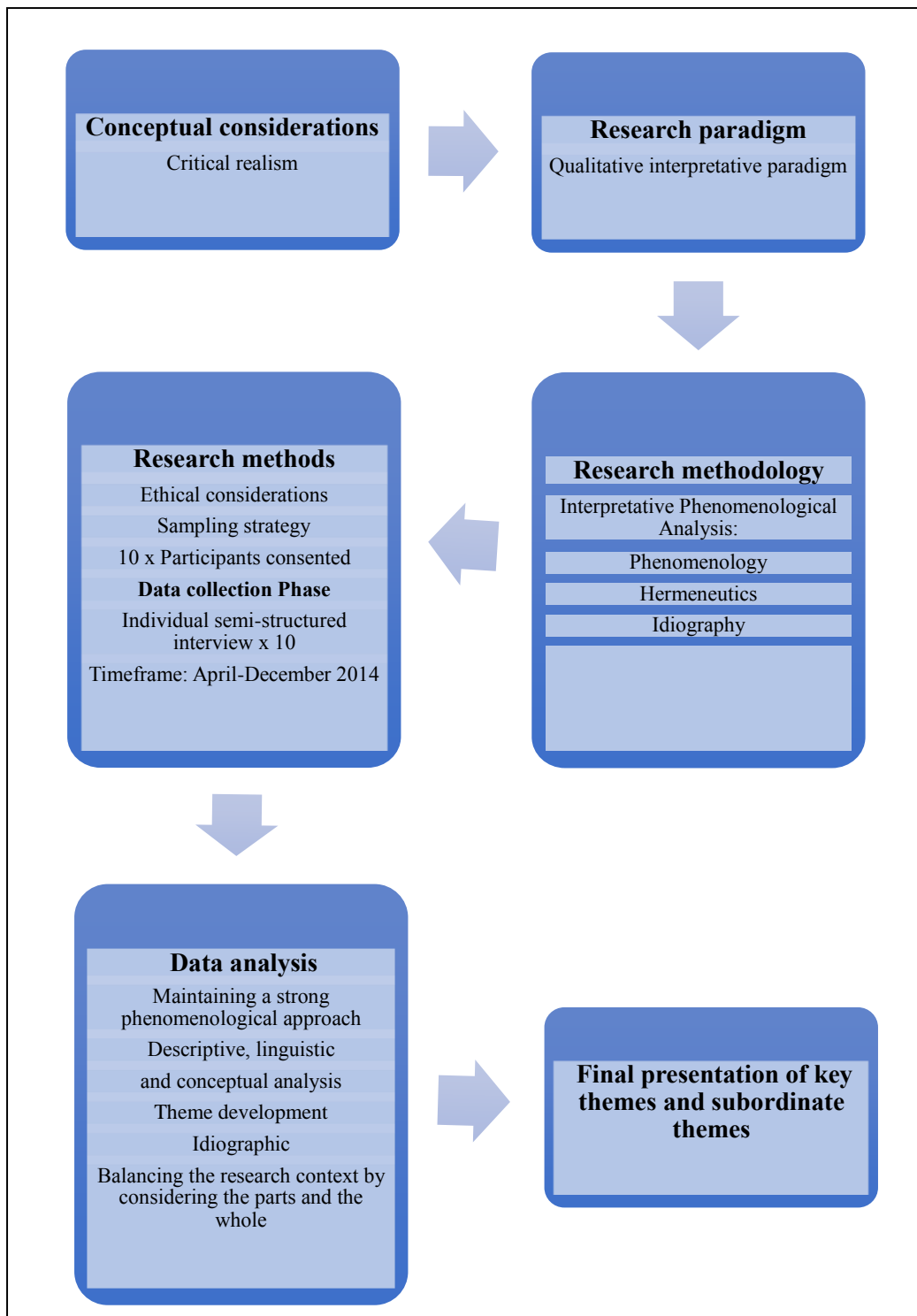


Figure 5.1: This study's research process

5.2 Ethical considerations

This section outlines the stages undertaken to ensure that ethical and governance principles and procedures were adhered to during the course of the study.

5.2.1 Ethical approval

A key principle underpinning this study is that every individual matters; therefore, they should be treated with respect (Johnson and Long 2015). Each step of the ethical approval process was guided by this principle.

Ethical approval was granted by Cardiff University's School of Healthcare Science Research Ethics Committee (REC) (Appendix two). As I was recruiting pre-registration healthcare students from within my own organisation, my proposal and Cardiff REC's recommendations were submitted to my own HEI's Institute for Health Research Ethics Committee (IHREC) for final approval. On the premise that I fulfilled Cardiff's recommendations, the IHREC granted permission for my study to proceed (Appendix three).

Researching in one's own institution can be fraught with ethical dilemmas (Ferguson et al. 2006). Clark and McCann (2005) detailed some of the possible dilemmas: avoiding an unequal power relationship and coercion; obtaining a valid informed consent; anonymity and confidentiality of data; and fair treatment. These could potentially make aspects of the study difficult to achieve. These are discussed within the sections below.

5.2.2 Participant safety

Foremost on the researcher's agenda is the participant's safety as the potential level of harm to the participants depends on the nature of the research (Johnson and Long 2015). Minimising harm or doing no harm (non-maleficence) to the participants is one of the key ethical principles underpinning research and nursing practice. Other key ethical principles are beneficence (doing good), autonomy (of the participant's decision-making capabilities) and justice (people in same circumstances should be similarly treated) (Beauchamp and Childress 2013).

As both an experienced nurse lecturer of 13 years and a RN of 28 years, abiding to my professional code of conduct (NMC 2015) necessitated I place safety as a priority, regardless of whether it is a patient's or participant's. Being able to identify distress in the participants during any stage of this study lay within my abilities due to my experience supporting struggling students in clinical placements. I was available to discuss any outstanding issues with the participants, if they felt the need to do so.

If the participants required further support networks, the university's student support services, personal tutors or occupational health services were accessible.

5.2.3 Researcher and participant relationships

This study involved pre-registration nursing students so I had to negotiate times of access with their course co-ordinators, this is pertinent as I was trying to recruit from three fields of nursing (Adult, Child and Mental health) and across the three years of each nursing programme. As I was an Adult nurse lecturer based on one of the three campuses, I had regular contact with the Adult nursing students throughout their three-year course, especially those on my base campus or in the placement areas I supported as a link lecturer. The only contact I had with the Children's and Mental Health student nurses was in their first year as I taught on the generic nursing Skills module. This made access more difficult to negotiate with non-Adult field student nurses, which is reflected in 9 of the 10 participants being from the Adult field.

The potential power differential was greater with the Adult nursing students because of my role; additionally, as McConnell-Henry et al. (2011) indicated, the power differential lies towards the researcher, which may lead the participants to say what the researcher wants them to say. This possibility led to any Adult field students allocated to me as a personal student being excluded from this study.

When I was explaining the study's purpose to the student groups, I made it clear that it was about *their* experiences of humour within the clinical setting and no two experiences would be the same. I also emphasised that there was no obligation to participate in this study.

During the interviews, I sought to remain aware of any power differential for, as Kvale and Brinkmann (2009) noted, interviews have a purpose and should not be considered open dialogue by equal partners. I decided against wearing my clinical uniform (which demonstrated my status/role within the university) when I interviewed the participants in the clinical setting. As I previously knew some of the students the rapport established at the beginning of the interview built on what I knew about them already. For the students I had not previously met I started each interview by asking them about themselves and giving a short synopsis of my own background. Martin (2016) stated that putting the participants at ease is a vital role of the interviewer. As

with patients, using one's communication skills facilitates this to ensure a safe and fruitful interview (Baillie and Black 2014).

5.2.4 Informed consent

Johnson and Long (2015) established participants should be given enough information to make an informed choice as to whether to participate or not. One step to obtaining informed consent is achieved through the quality of the information given (Walliman 2008). Johnson and Long highlighted the necessity of making any readable information accessible by considering the presentation and clarity of the material. The participant information leaflet and consent forms (Appendix one) was based on templates used in previous studies within the institution and was adapted to contain the information in an understandable manner.

To assure autonomy, when I met the individual nursing groups the information regarding the research project's aims was presented. The participation information leaflet was distributed at the time and the students were given the time and space to ask all their questions as well being given the researcher's contact details if any follow-up questions were required. This is in keeping with Johnson and Long's (2015) suggestions.

To ensure informed consent, any risks or benefits, and strategies for emotional distress, were discussed (Ferguson et al. 2006), especially if the student recounted an unpleasant experience from the clinical setting.

Consent forms (Appendix one) were handed out in the classroom and students were asked to place the completed consent forms into the submission box used for paper based assignments, or to email the researcher directly a scanned copy. This allowed the students time to consider participation in the project as well as assuring privacy from class colleagues regarding participation. At this stage, the importance of the right to withdraw, or not to participate, without repercussions was stressed due to my dual role of researcher and academic. Polit and Beck (2012) emphasised the participants' right to self-determination, evident in their right to ask questions and not expect to be exposed to any forms of coercion.

Guarantees were given that any grades or continuation on their course would not be jeopardised by their involvement (and the events they share) or by their non-

participation. This was to ensure fair and equitable treatment, especially as the research topic is based around their experiences of humour use within the clinical setting, which is neither taught nor assessed on any of the university's healthcare courses.

5.2.5 Confidentiality

Each participant's right to confidentiality was respected within this study. Bowling (2002) explained the issue of confidentiality should be addressed within the participant information form. Cohen et al. (2007) expanded on this by noting when accessing potential participants the meaning and limits of confidentiality should be clarified. During this study's recruitment session, I spoke about the emphasis on confidentiality and indicated the additional information in the participant information leaflet.

Polit and Beck (2012, p. 162) described confidentiality thus:

a pledge that any information participants provide will not be publicly reported in a manner that identifies them and will not be accessible to others.

Each participant was assigned a pseudonym which was used throughout this project. All identifying names were replaced with a pseudonym. The use of pseudonyms, as explained by Gerrish (2015), is to protect the anonymity of the participant, thus making the individual participant unrecognisable in the reporting of this study. Interviews were scheduled at the local university campus or a local site, based on convenience for the participants. Data were to be recorded using a digital voice recorder and the digital files stored electronically on a password-protected computer.

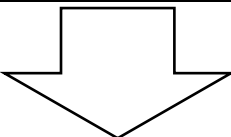
5.2.6 Withdrawal

Participants were informed they could withdraw from this study at any time without any consequences to their present/future grades or further continuance on their pre-registration course.

If withdrawal from the study was requested the participant's data was still to be included unless they explicitly expressed its exclusion, as per the participant information leaflet. There was no attrition during this study.

Further steps within the research process are presented in the summary below (Table 5.1) and these are dealt with in more detail in subsequent sections.

Table 5.1: Data collection summary

The data collection summary				
All pre-registration nursing students	Students must have completed at least one clinical placement	627 students eligible to participant	Presentation of the study to HEI colleagues and course co-ordinators to explain the purpose and design. Access to individual student groups negotiated with course co-ordinators	Explanation of study's purpose and distribution of participant information leaflet and consent form to individual cohorts of student nurses
				
67 students signed the consent form (given directly to researcher or posted in paper assignment box)	Individual students emailed via university system to establish continued interest in participation	24 students replied, and a second email (university account) followed to make interview arrangements	10 participants made arrangements to complete the interview	End of data collection phase

5.3 Data storage

Each participant consented to having their interview recorded. The interviews were recorded using the Audio Memos app on my university iPad, later downloaded onto my laptop. Both the iPad and laptop are protected with passwords known only to me. Recorded data was deleted from the iPad when all the interviews were completed but remained on the password-protected laptop until completion of this thesis.

All interview transcripts were saved onto the laptop under pseudonyms and, in keeping with best practice, each student's individual documents, such as interview transcript or analysis, were password protected on the laptop (Boddy et al. 2010). All paper copies of the transcripts, themes and any other written information were stored in a locked filing cabinet, inside the fob-activated lock system of my university office (Polit and Beck 2012; RCN 2011).

5.4 Sampling

Another step within the research process was to select participants for the study. Smith et al. (2009) recommended using purposive sampling. Bowling (2002) explained that purposive sampling is a deliberate method of sampling in that it is based on a group of people/settings sharing particular characteristics. Creswell (1998) recommended that in phenomenologically-based studies the participants must have experience of the phenomena and have the ability to articulate their awareness of said experience. Hunt and Lathlean (2015) extended this to include participants who are able to provide relevance and depth to the phenomena being investigated, which according to Corben (1999) requires from the participants self-awareness and personal strength, hence why sampling is purposive and small in number.

In this study, student nurses, from any field of nursing, were selected as they were able to offer access to the students' perspective of humour within the clinical setting. Student nurses were chosen as they share key commonalities with regards to programme design, professional expectations and patient contact. This offers certain homogeneity to the sample group. Doordan (1997) explicated that the homogeneity of a sample is based on how similar the participants are with regards to some characteristics. Smith et al. (2009) stated that homogeneity can vary from study to study as research studies' meaningfulness to participants differs. Ensuring homogeneity is imperative as it is a fundamental part of IPA (Smith et al. 2009).

In order to ensure a certain level of homogeneity of experience, there were two inclusion criteria for this research:

- Participants should be pre-registration nursing students
- Participants should have completed one practice placement experience.

5.4.1 Sample size and participant selection

Hunt and Lathlean (2015) detailed a pragmatic solution to the complexities of deciding a study's sample size: it should be large enough to produce sufficient data, in richness and depth, to address the research question.

Due to the idiographic approach advocated within IPA studies, and the need to capture an in-depth account of the individuals, Smith et al. (2009) recommended engaging a small number of participants. For professional doctorate studies, Smith et al. advised between four and ten interviews as standard guidance. The number of interviews rather than participants is stipulated allowing for flexibility in the data collection stage as the same participant can be interviewed at different stages of the study. In this study, ten students, meeting the inclusion criteria, volunteered and offered me time; I decided to interview ten individuals which is contingent with IPA best practice (Smith et al. 2009).

5.5 Recruitment of participants

As the sample group came from my own institution, I felt it necessary to inform each course team of the study's design and research question. After I presented my study in a departmental meeting to inform colleagues, access to the student groups needed to be negotiated with individual course coordinators.

On accessing a student group, I explained the study's purpose and distributed participant information leaflets and consent forms (Appendix one). I also arranged for announcements to be placed on the university's virtual learning environment for groups whom I could not access face-to-face due to certain logistical and organisational difficulties.

Of the 627 potential participants, 67 students returned a signed consent form, either directly to me or via the internal post (paper assignment box). These candidates were emailed on their university email accounts to establish further interest in participation. Following on from the 24 replies, a second email was sent to make arrangements for the interview. Only ten participants replied to make final arrangements for the interview. These ten students were interviewed.

Polit and Beck (2010, p. 1456) established in order to achieve a "thick description" for the reader, the researcher should provide basic information such as age, gender, ethnicity and where the data was collected.

Table 5.2 presents an overview of the participants' characteristics.

Table 5.2: Overview of participants

Participant (pseudonyms)	Gender	Age of individual in years	Ethnicity	Field	Year of programme	Previous healthcare experience	Current placement (at interview)	Place of interview
Laura	Female	38	White British	Adult	Mid-Year 2	Yes	In 4th	Hospital
Gaynor	Female	37	White British	Adult	Mid-Year 2	No	In 4th	Hospital
David	Male	36	White British	Adult	Beginning Year 3	Yes	In 5th	Hospital
Natalie	Female	22	White British	Child	Mid-Year 1	No	In 2nd	University
Kellie	Female	23	White British	Adult	Mid-Year 3	No	In 5th	University
Veronica	Female	24	White British	Adult	Mid-Year 2	Yes	In 4th	University
Sylvie	Female	23	White British	Adult	Beginning Year 3	Yes	In 5th	University
Ethel	Female	36	Black African	Adult	Beginning Year 3	Yes	In 5th	University
Sonia	Female	52	British Caribbean	Adult	Beginning Year 3	Yes	In 5th	University
Belinda	Female	31	Black African	Adult	Beginning Year 2	Yes	In 3rd	University

5.6 The practicalities of collecting data

This section concentrates on the practicalities of data collection and management, beginning with the study's plan. It then moves onto the data collection method of choice (semi-structured interviews) and the justification for its usage, before continuing to the development of the interview schedule and the interview process.

The plan for this project was to:

- Interview pre-registration nursing students
- Analyse the transcripts
- Utilise an IPA analysis framework, incorporating descriptive, linguistic and conceptual interpretation (Smith et al. 2009)
- Identify themes from each interview around how each participant uses their sense of humour in the clinical setting and its influences on their practice
- Identify themes from each interview concerning how each participant's sense of humour is influenced by the RNs
- Identify each participant's definition of humour.

5.6.1 Choosing the data collection method

Choosing the right data collection method must fit with the methodology and the research question. Langdridge (2007) proposed that the most commonly used data collection tool within phenomenologically based research is the interview. An interview, as described by Tod (2015), facilitates the exploration, explanation or description of the lived experience and meaning of the phenomenon through the individual's perspective, which enables discovery of their lifeworld by the researcher (Banner 2010).

Smith et al. (2009) clarified that to capture the underlying principles of IPA, it is essential to choose a data collection tool that allows the participant to tell their stories, thus offering a rich, in-depth account of their use of humour within the clinical setting, with associated thoughts and feelings. The purpose of these interviews was

to gather the participants' experience of the phenomenon of humour within the clinical setting. Therefore, a semi-structured interview was chosen.

5.6.2 Rationale for using semi-structured interviews

Interviews can take many forms. Walker (2011) discussed the continuum of interview types and explained these are linked to the response depth sought and the researcher's control over the content and process of the interview. Smythe et al. (2008, citing Gadamer 1982, p. 345) offered an alternative viewpoint on the phenomenological conversation. They drew on Gadamer's quote:

We say that we 'conduct' a conversation, but the more fundamental a conversation is, the less its conduct lies within the will of either partner.

Van Manen (1997, p. 66) stated the interview type is determined by "the fundamental question that prompted the need for the interview in the first place". Britten (2006) suggested all interview formats have some degree of structure otherwise generated data may not answer the research question. Smythe et al. (2008) echoed this sentiment because they highlighted that, even within the uniqueness of each conversation, the researcher's use of unscripted "umm" filtering into the interview can have the effect of encouraging, affirming or leading the participant. Lowes and Prowse (2001) commented, from their own research, on how participants appreciate guidance from the researcher within the interview, which provides some structure.

Smith et al. (2009) suggested a semi-structured interview due to its flexibility for both the participant and researcher. Bryman (2012) explained semi-structured interviews use open-ended questions on specific topics whilst affording the participants freedom to describe the richness of their individual experiences, which Craig (2017) maintained is consistent with Heidegger's notion of time and place, as it is context-specific. From the participant's perspective, it places them at the centre of the process by giving them the prospect of telling their story from the expert perspective whilst affording them space to think and build a meaningful rapport with the researcher (Reid et al. 2005; Smith and Eatough 2007). From the researcher's perspective, it presents a chance to have a purposeful dialogue with an experiential expert (Smith et al. 2009; King and Horrocks 2010; Pietkiewicz and Smith 2014). Walker (2011) maintained it is the semi-structured interview which seeks to uncover the person's lived experience.

Lowes and Prowse (2001) suggested that phenomenological interviews are never objective as the researcher's pre-conceptions cannot be eliminated, hence the product of the interview is co-created. A researcher as an active co-creator may nevertheless use interviews to unravel and discover what the participants think, and feel, about using humour in the clinical setting, as IPA assumes a connection between "people's talk and their thinking and emotional state" (Smith and Osborn 2007, p. 54). This allows the researcher to explore 'in the moment' participants' responses to posed questions to reveal the meaning placed on the events experienced. This is in keeping with Heideggerian principles: as Lowes and Prose (2001) explained, the interview product is a co-construction since there is a reciprocal influence.

From a pragmatic point of view, Walliman (2008) and Polit and Beck (2012) highlighted the challenges of face-to-face interviewing in terms of time and organising the logistics (travelling time, venue and parking); therefore, a single semi-structured interview approach was used to minimise human and monetary costs, as recommended by McConnell-Henry et al. (2011).

According to Ajjawi and Higgs (2007), a further advantage to using semi-structured interviews is the possibility for cross-interview comparison, as some of the questions posed will be the same. Semi-structured interviews are complemented by a schedule which provides novice researchers direction and guidance, which can be comforting whilst opening opportunities to explore the participants' narratives (Smith and Eatough 2007). From a power-symmetry perspective, the participant becomes an "active agent" in the interview process (Smith and Eatough 2007, p. 43). Nonetheless, the interview remains a professional conversation between researched and researcher, so a power asymmetry endures (Kvale 2007).

5.7 The interview schedule

Preparation for the semi-structured interviews requires the development of an interview schedule with questions based on topics derived from both the research question and current literature. The focus of the preparation should include the type and sequencing of questions; the questioning technique of the interviewer and relevant prompts to aid exploration of the participants' narratives; and the ensuring of

the comfort of both interviewee and interviewer in both physical and psychological terms (Smith et al. 2009).

5.7.1 Development of the interview schedule

Drawing on IPA's authors, the purpose of the schedule is to encourage a detailed narrative of the participants' experiences of the phenomenon under study, through a purposeful conversation guided by pre-prepared questions as contemplated, in advance, by the researcher (Smith and Osborn 2003; 2007; Smith et al. 2009; Pietkiewicz and Smith 2014). Additionally, it enables the answering of the research question, drawn from explorative themes identified after a review of current literature sources (Langdridge 2007; Smith et al. 2009).

If the aim of IPA is to enter the participant's psychological and social lifeworld, then the questions can be considered the keys to their lifeworld (Smith and Osborn 2003, 2007). Achieving this is possible through the types of question used – which Smith et al. (2009) detailed as being: descriptive, narrative, structural, contrasting, evaluative, circular and comparative – and the use of prompts and probes. These should be open, neutral, non-explicit questions/prompts enabling the participant to talk more than the interviewer (Smith et al. 1999; Smith and Osborn 2003; 2007; Finlay 2011). Table 5.3 below shows the interview schedule developed for the semi-structured interviews.

Table 5.3: Interview schedule

Questions for interviews
How would you describe how you use your sense of humour in the clinical setting?
How do you think your sense of humour influences your clinical practice?
How would you describe the registered nurses' attitude towards the use of humour? And how does it impact on their use of humour?
How would you describe your own use of humour in the clinical setting?
How do you describe/define humour?
In your experience, how does humour form part of compassionate care?
Is there anything else you would like to add about your experience of humour in the clinical setting?

These questions derived from the research question about pre-registration students' experiences of humour within their clinical placements between themselves and mentors and/or patients, with additional influence from my previous review of the current literature.

The interview schedule comprised six main questions and two sub-questions, as Smith et al. (2009) recommended six to ten questions with prompts. The interview schedule was discussed with a nursing (mental health) colleague and a fellow PhD student, as suggested by Smith et al. (2009). Some of the question wording was changed to facilitate more open questions to enable greater participant dialogue. McConnell-Henry et al. (2011) explained the use of 'how', 'who', and 'when' questions are preferable as it allows the participants to elaborate and clarify their experiences, which they maintained aligns with Heidegger's context-specific truth (p. 33). King and Horrocks (2010) emphasised the potential complexity of the question format, and Langdrige (2007) highlighted that if one question contains multiple smaller questions or is complex in nature this can result in the participant feeling intimidated, saying what is expected of them or being unsure what to answer. Therefore, a simple, single-issue question format was used to focus the participant's attention onto the topic being covered.

Pietkiewicz and Smith (2014) identified how the novice researcher benefits from having specific questions, whereas Eatough and Smith (2008) highlight the novice interviewer's concerns about departing from the schedule as this requires skill and confidence. Smith and Osborn (2007) advocated memorising the schedule, which acts as a mental prompt for the interviewer, resulting in fewer distractions for both parties. Craig (2017) explained how using a schedule enables the researcher to concentrate on the participant's description of their experiences of the phenomenon (humour within the clinical setting). For transparency reasons, I provided each participant with a copy of the interview schedule even though the sequencing may have been adjusted to suit the flow of the interview.

Utilising Smith et al.'s (1999) and Gerrish's (2015) suggestions, the sequence for the schedule was based on the following:

- Think about broad question areas to be covered
- Put areas in appropriate sequence – leave sensitive questions to later as the participant, through the rapport built, would be more comfortable and relaxed
- Think of appropriate questions related to each identified area
- Think of probes and prompts as these uncover participants' meanings.

This kind of sequenced approach, Cohen et al. (2007) described as funnelling. For Smith and Eatough (2007), the sequencing of the questions is less important; however, Smith et al. (2009) proposed beginning with broad questions which relax the participant before moving to specific questions which may cause discomfort for the participants. Hefferon and Gil-Rodriguez (2011) maintained that broad questions allow the participant to set the boundaries so that the potentiality of the researcher imposing their understanding of the topic onto the narrative is diminished, as detailed by Smith et al. (2009). According to Langdrige (2007), this funnelling effect allows the participant to concentrate on their narratives and subsequent concerns.

Smith et al. (2009) propose it is specific accounts of the particular experiences with the accompanying cognitive and emotional process which produce the best data. To accomplish this, one must “go deeper” (Smith et al. 2009, p. 68). McConnell-Henry et al. (2011) explained: the aim of a phenomenological interview is to expose the participant’s inner voice, encouraging depth, preferably in their own words. Walker (2011) expanded on this by describing the use of probing questions to aid clarification of participant’s responses or to elicit further detail of the participant’s experiences (Kvale and Brinkmann 2009). When necessary, I sought immediate clarification from the participant within the interview. This, according to Stein-Parbury (2018), generated understanding of the participant’s world, which is the prime objective of phenomenological interviewing.

During the interviews I used a range of question formats such as probing, follow-up or clarification (Kvale and Brinkmann 2009). Table 5.4 below offers examples of questions used.

Table 5.4: Unscripted interview question examples

Can you think of an example?
What does it mean to you?
That’s interesting. Do you think culture plays a role in who you use humour with?
Can you tell me more about that?
What for you is ‘appropriately’?

Craig (2017) mentioned how she used conversational nudges such as “mmm” or “go on” to foster participants’ thoughts. In my case, I found myself also using “mmm” or more often “yeah” or “aha”. Additionally, silence is considered a good technique for

participants to gather their thoughts, one I used often. For me, using conversational nudges signalled to the participants I was listening to what was being said. McConnell-Henry et al. (2011) proposed researchers listen with the intent to interpret by drawing on Heidegger's statement "to live is to listen, interpret and learn from the stories others convey" (p. 33).

5.8 The interviews

Ten semi-structured interviews were conducted lasting from 20 to 61 minutes.

The interview venue was chosen by the participants, ensuring an environment they were comfortable and familiar with (Smith and Osborn 2003), one which supported their emotional and physical well-being (Gerrish 2015). Seven participants chose the university whilst the other three chose their hospital base. Although these areas could not be completely free of interruptions nor timetabling issues, each venue provided an area within which the students could talk freely. The timings of the interviews were dictated by the student's off-duties, often taking place after their placement shift or classes.

Gillham (2005) emphasised the need to ensure, prior to interview commencement, that the environment is pleasant for the participant with regards to heat, seating arrangements, refreshments, functioning recording equipment, and a presentably dressed interviewer. From the power symmetry perspective, the seating arrangements ensured no physical barriers between us: when sitting in the classroom, I placed the writing tables of the chairs in the raised position, and situated the chairs facing each other.

Each interview began the same by checking the participant's continued consent to proceed with the interview. Continuing with conversation about either their current placement or university lectures, I began to build rapport with the participants, especially if I did not know them (as was the case with seven of them). Of importance here was the need for me to concentrate on my role as a researcher rather than as a nurse educator (Biggerstaff and Thompson 2008). Langdridge (2007) accentuated the need for trust as this assists both parties to relax into the interview. Again, within the preamble, explanation of the project was reiterated along

with issues of anonymity, confidentiality and, most importantly, that it was their story of their experience so there was no right or wrong answer (Smith et al. 2009).

Whilst most of the participants chose not to look at the schedule during the interview, Gaynor did. I wanted to address each participant's fear of the unknown even though this departs from Smith et al.'s (2009) advice on the use of the schedule. The phraseology of the interview questions was adapted to facilitate understanding with different participants, either due to word choice or the interviewer's pronunciation of words; plus, the question sequence varied according to the participant, thus affecting the length of the interview.

I worked my way through the interview schedule using probes to elicit further depth to the participants' responses, thus extending their narrative. It was only through probes such as "can you explain a little more what you mean..." that the participants began to be open about their experiences regarding humour within their clinical practice. This strategy aided the utilisation of the double hermeneutic which is characteristic within IPA (Smith et al. 2009). Another strategy used was asking for examples, which mainly focused on their experiences with patients. This allowed me to understand and appreciate their stories without being too intrusive (Gillham 2005).

Allowing the participant to talk at their own pace enabled detailed answers to the questions, even if they had covered a forthcoming question, and signalled my flexibility as the interviewer within the interview process (Langdridge 2007; Smith et al. 2009). Sometimes it was necessary to seek clarity as I might not have heard of some of the terms used within the context of the anecdote being told.

When sensing something remained untold, as in Kellie's interview, using prompts or probes, or "forms of responsive engagement" (Gillham 2005, p. 32), is another questioning technique which can elicit underlying meaning (Langdridge 2007). Using silence can be an interviewer's friend or foe, because either the participant is using the time to think, or they may have nothing more to say (Langdridge 2007). King and Horrocks (2010) proposed an under-communicative participant may have continuing confidentiality or anonymity issues; therefore, they suggest re-confirming data protection storage and use of contributed data.

Gillham (2005, p. 31) stated that “listening demands intense concentration”, which matches my perspective; therefore, I chose not to take notes during the interview as I felt by giving the participant my full attention this signalled my valuing their time and responses. Smith et al. (2009) explained close attention must be paid to the participant’s words as this enables the interviewer to enter their world and potentially enables the interviewer’s own concerns to be set aside.

Interviewing should not solely rely on the verbal skills of both interviewer and participant. Pietkiewicz and Smith (2014) acknowledged the importance of observing the participant’s non-verbal reactions to the interview. So, the interviewer needs to be receptive to the participant’s moods, body language and attentive to their concerns by actively listening and watching (Gerrish 2015). Failing to watch the participant’s lived experience within the interview is commonly seen as an omission within phenomenological studies (Finlay 2006). Although I chose to delay writing my notes until immediately after the interview, the entries recorded still evidenced participants’ apparent uncomfortableness caused by certain questions or their frustration at not being able to answer. For example, one began to fidget in their seat and avoid eye contact when unable to think of humour examples.

Concerning the natural end to the interview, I determined this from whether they felt that they had told their story to their fullest satisfaction. If discussion points about their course arose that my expertise as an RN, nurse lecturer or personal academic tutor highlighted, this was dealt with. This occurred with Laura, David, Veronica and Sylvie and does not fall into the remit of this study, since it concerned certain course requirements. After the participant had left my company, I wrote in my journal about my general impressions: how the interview went; what I thought the main themes were; any underlying tones; progress of the interview; and if any questions arose from it for me. An extract from my interview notes based on Darawsheh’s (2014) framework is found in Table 5.5 below.

Table 5.5: Extract from my interview notes

Adjusting researcher's action and the research process			
Context of reflection	Trigger for reflexivity	Thinking about my own thinking	Outcome of reflexivity
Interview 1	Asked all questions on the schedule	The use of the schedule gave me confidence and here I needed to ask myself if this was about having the 'power' as I'm the lecturer?	Each participant given a copy of the schedule before the interview started. Gained confidence in letting participant take control
	The level of emotion with which she was speaking	Reminded me of emotions felt within my final year of training – placed me in a vulnerable situation	Being aware of participant effect on me and the need to work it through in supervision, peer debrief and research journal.
	Absence of closing	I do realise the need for closure	Ask remaining participants if anything to add and the need for a debrief

During an interview, the phenomenological focus is on the participant's experience of the topic under investigation and how it appears to them within their lifeworld (Smith 2011a). However, within IPA the hermeneutic element present is based on the centrality of the interviewer: the dual interpretative activity (double hermeneutic) requires the participant to explore and make sense of their world as an insider whilst the researcher, as an outsider, attempts to make sense of the participant sense-making and meaning-finding within their lifeworld (Eatough and Smith 2008). Smith et al. (2009) made a distinction when employing the double hermeneutic by comparing the participant's meaning-making (first order) versus the researcher's sense-making (second order).

5.9 Transcription of interviews

Both Cohen et al. (2007) and Langdridge (2007) claimed that transcription is one step away from the immediacy of the interview, devoid of the context and dynamics of the research encounter. Bryman (2012) extolled how the researcher becomes closer to the data by transcribing the data themselves and how it is an interpretive act, as discussed by Smith et al. (2009). Knowing myself, this would not be the case

since I would have concentrated more on the mechanics of the transcription (such as ensuring that I have written the right word), eventually becoming extremely frustrated with the process and loss of hours. Smith and Osborn (2003) describe how one hour of transcription can be seven hours in real time. Therefore, I engaged a transcription service recommended by colleagues who had previously used the service for their research.

The transcription service instructions centred on Smith and Osborn's (2007) recommendations that it must be verbatim to include all exact words spoken, both participant and interviewer, including "um"s and "ah"s. Deliberately leaving in wrong pronunciation, grammar and tense usage enabled me to stay as close to the participant's experience and its associated meaning as possible; it was also respectful to the participant as this is how they told their story (Langdridge 2007).

On receipt of the completed transcripts, I re-listened to the audiotapes checking for accuracy, amending spelling mistakes and adding words misunderstood or omitted. Furthermore, annotation relating to pauses, laughter or silence breaks was added. Smith and Osborn (2003, 2007), Smith and Eatough (2008) and Smith et al. (2009) described how IPA interpretation focuses on the meaning of the content occurring at the semantic level rather than the prosodic elements (intonation, rhythm, tone and stress). Therefore, annotation of the prosodic elements on the transcript is not as necessary as it would be if undertaking a conversational analysis. At this stage, the transcript formation was amended to aid the analysis process by adding wide margins at each side and pseudonyms (Smith et al. 2009).

Re-listening to the audiotapes with the completed transcripts enabled me to become more familiar with the data and I began to have initial thoughts about the themes emerging (Smith et al. 2009); I thus added these thoughts and impressions to my journal.

5.10 Quality measures

The interpretation of any study's findings is only one-sided (Willig 2001), thus it is essential to ensure the transparency of the process to establish the integrity of the study.

Smith et al. (2009) advocated using Yardley's principles to assess the validity and quality of IPA studies. Yardley (2000) explained conventional criteria for assessing a study's quality, such as reliability and replicability, are not permissible when investigating people's experiences. She therefore proposed the following criteria: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. Each principle, supported by specific examples, is outlined below.

5.10.1 Sensitivity to context

Sensitivity to the context, as suggested by Smith et al. (2009), occurs at the early stages of IPA. Clancy (2013) detailed how knowing your own positionality and developing critical self-awareness is needed for doctoral study, as the absence of these can potentially lead to bias and prejudice. She explained your positionality is influenced by ethnic group, age, gender, who you are and where you stand within society; some of these factors are explicit within my prologue.

This study demonstrated sensitivity through establishing the current context of nursing, and associated threefold expectations of students, through a wide-ranging literature review and subsequent design of the research question. Interview sensitivity was demonstrated by prompts being used when the students struggled with the topic.

Another part of sensitivity is how the interview participants interacted, inclusive of body language. Finlay (2006) and Langdridge (2007) introduced the notion of embodiment within the interview process (influenced by Merleau-Ponty's argument that the body is our way to understand and connect to the world and is, therefore, the "vehicle for experiencing doing, being and becoming", Finlay 2011, p. 29). Finlay first discussed bodily empathy – being attentive to the participants' bodily gestures and demeanour – explaining that a researcher can attempt to understand the other's feelings, therefore reaching deeper into their experience than one would by simply observing their body language (Langdridge 2007; Finlay 2011). Taking Kellie's example (Appendix six), she fidgeted through the interview, especially when discussing how humour helped her survive the nursing course. This feeling of awkwardness signalled to me discomfort with the process but could have been more about the level of vulnerability she felt when discussing her struggles. Moving onto

embodied self-awareness – this relates to the researcher’s probing their own lived body experience through the process; however, caution was advised (Finlay 2006) that the researcher’s voice does not displace the participant’s voice.

Being sensitive to the individual participant’s context is demonstrated in the idiographic accounts (see Chapter six), with emphasis on their linguistic use which communicates what their lifeworld was like at that moment in time.

5.10.2 Commitment and rigour

My commitment to understanding IPA as a methodology was made apparent by my attendance at the London IPA group, London based IPA training days (Hefferon and Gil-Rodriguez 2015, the 2017 IPA conference, and Glasgow Caledonian University’s IPA Analysis workshop, Flowers and Dickinson 2017). My commitment to understanding the meaning of humour to the participants was made evident when I re-analysed the first four interviews: being committed to hearing the participants’ stories, by silencing my own voice, through the use of open formatted questions or prompts all enabled me to dwell in their lifeworlds. Further commitment towards the participants was shown in the recruitment phase and in how the data was stored. Continual reflexivity (for example, the interview balance between participant and researcher, and the self-doubt creeping in about the participant’s voice being heard within the interview) and engagement with peers and supervisors evidenced my commitment to the process. I completed Kvale’s (2007) criteria for interviews afterwards to ensure the interview balance and to better my interview technique for the next participant.

The congruity between the steps of the research process (the research question, methodology, data collection method and analysis) should be visible to the reader (Koch 1994). Following Smith et al.’s (2009) guidelines enabled this study to be conducted in a systematic and rigorous manner, demonstrated by:

- The sampling strategy and the homogeneity of the sample used to answer the research question (see section 5.4)
- The provision of full descriptions of the interview schedule and process plus the threefold (descriptive, cognitive and linguistic) analysis because they show

the interpretation moved beyond a simple description of the participants' stories

- In-depth interviews that obtained rich data
- The ensuring of idiographic in-depth accounts (such as the biographies, section 6.1 which reveal a systematic engagement with the analysis steps as detailed above. These permit the reader to comprehend the meaning of humour for the individual participants
- The representation of the individual within the superordinate theme through the use of quotes (Smith 2011a)
- Proportional verbatim quotes in each theme from participants, because a quality indicator of any research project's process is trustworthiness, which is how close the researcher stayed to the participants' voices (Clancy 2013).

Auditability of the decisions made in this research study and the congruency between the researcher's philosophical stance, research methods and underpinning paradigmatic assumptions can be considered other aspects of rigour (Topping 2015). Throughout my doctoral journey, I participated in regular supervision sessions and annual monitoring reviews, which enabled me to discuss the rationale behind any decisions made. I documented decisions made in my research journal, which remained a source of information throughout the writing-up of this study. The congruency of my philosophical ideals, the research process and the underpinning paradigmatic assumptions are established in the prologue and the methodological justification. Maintaining an audio reflective diary and attending the London IPA groups facilitated peer discussion to uncover any biases or assumptions I had (Noble and Smith 2015).

5.10.3 Transparency and coherence

In Smith's (2011a) IPA quality guide, one of his four criteria is transparency, which is the clarity offered to the reader of the execution of the research study stages throughout. Tables such as the participant overview (Table 5.2) and the analysis steps (Table 5.6/Figure 5.3), as well as the schedule (Table 5.3), aid this process (Smith et al. 2009). Transparency of the analysis steps adopted within this study is

offered in the data collection (section 5.6 and is illustrated in a worked example in Appendix six (Kellie), which shows the progression from the idiographic account to the interpretative process to the superordinate themes.

Coherency was discussed in the sections above, that is, the fit of methods to paradigm, the writing up of the analysis and the visibility of IPA's commitment to phenomenology and hermeneutics (Smith et al. 2009).

5.10.4 Impact and importance

Yardley's (2000) final criterion is impact and importance. The importance of this study is to be found in it being the only known study that focuses specifically on pre-registration nursing students and their use of humour in the UK clinical setting. It is envisaged this study will contribute to the well-being of future nursing students.

5.10.5 Validity

Another quality indicator offered by Smith et al. (2009) is validity. The term 'validity' has often been associated with the positivist paradigm as a quality criterion (Smith et al. 2009, Polit and Beck 2012). Validity was called trustworthiness by Maggs-Rapport (2001). She stated that the data is only considered trustworthy and should be considered holistically when "the activity of research, the cognitive process of validating data and the involvement of external measures, second opinions and the subjects' own perceptions which add weight to the decisions made by the researcher" (p. 221) are transparent.

Smith et al. (2009) suggested an independent audit as a way of checking the "paper trail" (p. 183). For this study two independent audits were conducted. Firstly, an interpretative phenomenologist audited the data-analysis steps utilised by independently analysing one interview (Natalie) then comparing her findings to mine. Koch (1994) highlighted within the hermeneutic experience the reader may have a different interpretation but they should be able to follow the researcher's interpretation. Secondly, a critical friend checked the final report's plausibility and creditability (Smith et al. 2009).

Methodological limitations are considered in chapter 8.

5.11 Data analysis

IPA authors have considered the analysis guidelines in the IPA literature as a support rather than prescriptive steps (Smith et al. 1999; Smith et al. 2009). Therefore, the following shaped the structure of my analysis process: Smith and Eatough's (2007) stages of analysis guide; Smith et al. (2009); Finlay (2011) (see Table 5.6 below). I was also helped by the following workshops: Aston University's study day (Shaw 2014), the London IPA weekend workshop (Hefferon and Gil-Rodriguez 2015) and Glasgow Caledonian University advanced analysis workshop (Flowers and Dickinson 2017). Table 5.6 below offers an overview of the steps of the analysis.

Table 5.6: Stages of IPA analysis

Stages of IPA Analysis
1. Close and detailed reading of transcripts incorporating initial noting (on an individual level)
2. Gathering initial themes, organising them into clusters (on an individual level)
3. Refining themes, condensing and examining for connections across the participants' accounts
4. Creating a narrative account of the interplay between the interpretative activity of the researcher and participants' accounts of experiences in their own words (presented in chapter 6)

(Smith and Eatough 2007, p. 45; Smith et al. 2009; Finlay 2011)

Completing the analysis case-by-case enabled me to immerse myself into each participant's experience (Smith et al. 2009); these varied due to whom the student was, the field of nursing practice they were in, the placement areas experienced and their year of study. By reflecting via an audio reflexive journal and writing the first draft of my prologue, I was able to further articulate my own assumptions on these topics. Additionally, I delayed writing my literature review on humour. By undertaking these two actions, I was attempting to waive my natural attitude; what Finlay (2011) described as a taken-for-granted understanding and meaning of the phenomenon. This allowed me to become cognisant of my own assumptions, preconceptions of humour within both academically and clinically focused literature (van Manen 1997; Snelgrove 2014), and prior experiences (which were defined by Heidegger, 2010, as fore-conception). Attempting a Husserlian bracketing (attempting to ignore or suspend all of one's suppositions, van Manen 1997) was unrealistic because of the

interpretative nature of IPA: a central tenet of the latter is the recognition of the researcher's role within the interpretation of the participant's narrative (Brocki and Wearden 2006).

The hermeneutic circle, a metaphor for understanding and interpreting as the circular relationship between the part and the whole, allows rich descriptions of the participants' experiences to be produced and their voices heard (Koch 1996, Ajjawi and Higgs 2007). Polit and Beck (2012) explained within this circular relationship one begins to appreciate the transcribed interview in terms of the part and the parts in term of the whole. Lindseth and Norberg (2004) proposed three stages of engagement of the hermeneutic circle: naïve reading, emergence of key themes and interpretation of data. This is illustrated in Figure 5.2 below.

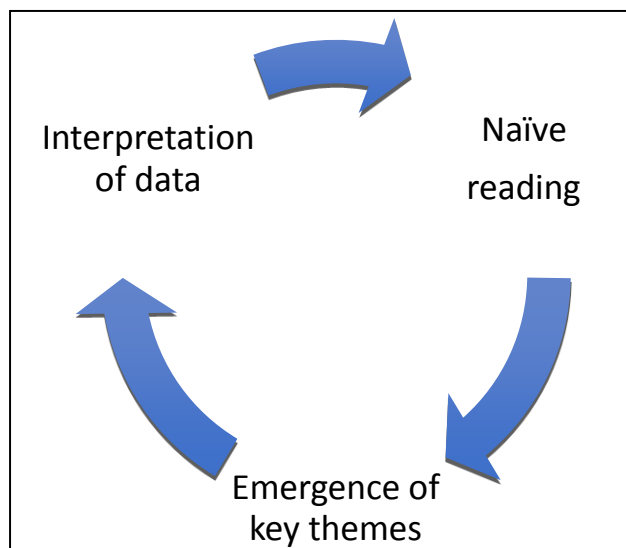


Figure 5.2: Lindseth and Norberg's hermeneutic circle (reproduced with permission from Craig 2017)

Ajjawi and Higgs (2007) maintained this is an iterative process with movement between parts (data) and the whole (evolving understanding of the phenomenon), with each stage producing partial understanding and building towards a fuller interpretation.

For the interview analysis process, I worked on paper copies which enabled me to maintain an overview of each participant's interview and how it was developing. On

the paper copy of the transcript, I used several colours to denote the three areas of interpretation required (Smith et al. 2009):

- Descriptive: the content, especially the subject the participant was talking about and language taken at 'face value'
- Linguistic: specific language use, namely laughter, tone, frequency of word repetition and use of pronouns such as I, fluency of speech, and the use of metaphors. I extended this category to include discourse markers and conversation fillers
- Conceptual: the more interrogative comments, which shift the emphasis of the analysis towards the participant's principal understanding of the discussion.

I read the complete transcripts repeatedly to actively engage with the data. The resultant familiarity with the participants' words aided my insight into their lifeworlds (Smith et al. 1999; Langdrige 2007), and at this stage I gave special attention to the data as a whole (Smith and Eatough 2007). This corresponds to the first stage of the hermeneutic circle of naïve reading in which the participants' ideas are expressed in their own words or phrases, thus capturing the detail of what the participants are disclosing (Titchen and McIntyre 1993). Ajjawi and Higgs (2007) considered these to be first order constructs. Being drawn deeper into their experiences moved me from an etic to an emic perspective (Reid et al. 2005), and I sought to imagine the participants' stories as told by each participant in order to 'step into their shoes' (Pietkiewicz and Smith 2014).

Many authors have recommended making initial notes about the participant, interviewer or content, focusing on significant relevance (Smith et al. 1999; Biggerstaff and Thompson 2008; Pietkiewicz and Smith 2014; Shaw 2014). Gee (2011) proposed a separate piece of paper for this, to reduce the feeling of being overwhelmed that is often present at the beginning of the analysis (Smith et al. 2009). Following Gee's advice I kept a piece of paper next to me for any thoughts which 'jumped' into my mind. I then moved to a line-by-line exploration of the text with a focus on semantics and the use of language, noting anything of interest, thereby beginning to delve into the particular: the details and meanings as seen by the individual (Smith et al. 2009, p. 83; Gee 2011; Snelgrove 2014, p. 21). Smith et

al. (2009) clarified that at this step there is a strong phenomenological focus, staying close to the explicit meaning in the form of objects of concern (events, places, processes, relationships and principles) and their associated meaning (Smith et al. 2009, p. 83). This captures the underpinning phenomenological principle of “how things seem to individuals” (Snelgrove 2014, p. 21).

I consistently asked myself, ‘what is the data saying to me?’, then wrote my thoughts onto the page, using the space to differentiate my comments (descriptive/linguistic on the left and bottom; emergent themes and conceptual coding on the right) and noting how “certain key words capture the essence of the analysis” (Hunt and Smith 2004, p. 1002), such as Kellie’s repeated inference of using humour to “keep on going”.

For each participant I listed their humour stories, whether about friends, patients or colleagues, noting if they instigated the humour and/or used humour support strategies (Hay 2001), and considered which humour theories could be applied, as listed in McCreddie’s interpretative framework (McCreddie 2008b, p 118-119: see Appendix four). Laughter can be considered a humour support strategy or can be used to signal a humorous occurrence within spontaneously occurring interactions (Glenn 2003). Therefore, laughter within this study was considered within the context of the interview as it is a semi-structured interaction with the purpose of eliciting the participants’ experience of humour (Smith et al. 2009).

The second stage of the hermeneutic circle is the emergence of themes from the naïve reading and the first order constructs (Ajjawi and Higgs 2007). Polit and Beck (2012) described a theme as being a rich description of the phenomenon. This fragmentation of the data, followed by its re-organisation, allowed for this researcher to move along the hermeneutic circle with the additional benefits of sense-making (Smith et al. 2009; Pietkiewicz and Smith 2014).

The third stage of the hermeneutic circle is the interpretation of the data from the second order constructs (Ajjawi and Higgs 2007). These evolve from the individual case’s themes. These constructs are created from the researcher’s personal and theoretical knowledge. As IPA acknowledges, the role of the researcher is to offer an alternative narrative through their sense-making of the participants’ accounts, drawing on their own interpretative resources (Smith and Osborn 2003; Eatough and

Smith 2008), it is important to recognise no one interpretation would be the same, as demonstrated in King et al. (2008); therefore, no generalised claims can be made.

Developing deeper interpretation of the text is achievable through specific analysis of metaphors and temporal references, as advocated by Smith et al. (2009) and Finlay (2011), although not expected of the novice researcher (Smith 2004). Within this study, temporal reference analysis lies in knowing which placement the students were discussing, and then comparing their personal pronouns usage, which signalled the stages of their socialisation journey. For example, Kellie felt part of the community nursing team and student team – noted in her usage of first person – but she would refer to “they” when discussing some RNs and their idea of professionalism.

Subsequently, there was a need to identify patterns across the themes in order to reduce them further. For this section, I used bold letters within the quotes to highlight themes and enable me to remain embedded within the data whilst analysing connections. I printed off a list of the emergent themes, cut it up, then began to formulate final themes by similarity (abstraction), opposites (polarisation), frequency of occurrence (numeration), or context (contextualisation) (Smith et al. 2009). My themes did not remain static; the names and groupings evolved throughout the process.

The last step of the individual case was to compile a list of the final themes and relevant quotes for use in the cross-case analysis phase. The process explained above is the description of the first two steps of the IPA data analysis (Table 5.6) conducted for each individual participant. Figure 5.3 (below) presents a diagrammatic illustration of the data analysis of an individual participant’s transcript.

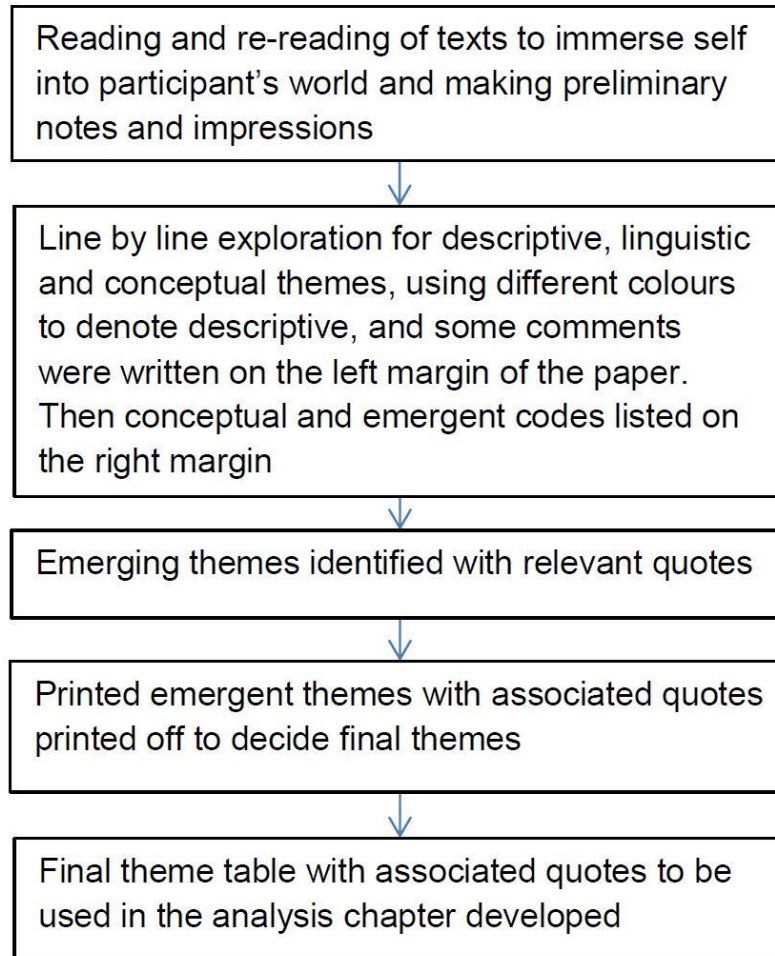


Figure 5.3: Overview of steps taken within my idiographic analysis of the interview

For each participant, although my fore-structures had changed, maintaining the phenomenological attitude allowed me to look at each new interview with an open mind, allowing it to speak for itself and for new themes to emerge, thus achieving an inductive and iterative approach in each analysis. Table 5.7 (below) offers a summary of the data analysis as presented in Figure 5.1, with reference to the hermeneutic circle, my notes and points of reflexivity.

Table 5.7: Data analysis summary in relation to the hermeneutic circle, and my research journal (adapted from Craig 2017)

Data analysis activities	Application of activity to study	Hermeneutic circle, research journal notes and reflexivity
Maintaining a strong phenomenological approach	Awareness of the phenomenon as an area of interest to me as a researcher/nurse	Acknowledging humour and my own experiences of it, my values, beliefs. Recognising my fore-structures foresight and fore-conception (in prologue)
Theme development: Initial through to identifying superordinate themes	Reading of the transcripts as a whole Identifying participant first order narratives Simultaneously listening to digitally recorded interview and reading interview transcripts Line by line analysis of transcripts Initial interpretation of findings in the emergence of initial themes Reflection on initial themes which characterise the phenomena Development of second order narratives by researcher Individual humour biographies and interpretation using McCreddie's (2008b) framework of humour theories and implicature of humour support (Hay 2001) Development of cross case analysis through the creation of master theme tables	Recognising my own humour experiences, values, beliefs and fore-structures Data driven to identify participants first order narratives Using interview notes, reflexive thoughts. Revisit interviews using hermeneutic circle (naïve reading) Identify initial emerging themes and sub-themes (descriptive, linguistic and conceptual) according to Smith et al. (2009) Rechecking transcripts by line by line analysis against initial themes and sub-themes using hermeneutic circle (emerging themes) Revisit interviews using hermeneutic circle (emerging themes based on humour support strategies and theories) Reflexivity, acknowledging my own fore-structures, experiences and beliefs to ensure it is the participant's voice being heard Reflexivity of my own fore-having, foresight and fore-conception in order to understand and interpret the meaning of data
Balancing the research context by considering the parts and the whole	Revisiting the findings and phenomenon as parts and with the whole	Revisit the findings. Pulling the 'parts' together (expansion of literature review)

I then wrote a biography of each participant (section 6.1) based upon a checklist including Smith's three areas of interpretation, their humorous experiences and their own definitions of humour. This concluded the idiographic (divergent) analysis of the ten interviews which produced provisional superordinate themes.

The next consideration was the convergent analysis of the ten participants' identified superordinate themes. The iterative process of the hermeneutic circle is present not only when reading the individual transcript but also when synthesising the superordinate theme development across the cases. Mapping the cross-case analysis for all participants produced the superordinate and subordinate themes presented in the following section.

5.12 The convergence of the individual superordinate themes

This section illustrates the building of the final, convergent superordinate themes. The aim here is to demonstrate the convergence of the themes that arise from the idiographic analyses of the participants' experiences of humour within the clinical setting. This enables further exploration of their lived experience, and associated meanings, of humour (Smith et al. 2009).

5.12.1 Superordinate theme building: the process

I printed the individual participants' superordinate themes onto different coloured sheets of paper. Cutting up the individual themes from the participants' coloured pages allowed me to cross-refer to my individual pouches of quotes (Appendix five).

Certain word usage from the participants ignited within me such strong visual imagery that it formed part of my analysis, for example the use of the expressions "changing" or "mirroring people" in Sylvie's account. Shinebourne and Smith (2010) proposed that a deeper level of understanding is added through visual imagery conveyed by metaphor use, which evokes within the listener an experiential response. Seto (1999) discussed how a synecdoche, a single word or term, refers to the whole of something or a concept. Other utterances or phrases were what Smith (2011b, p. 6) called "gems": those with a disproportional significance for the study. I called these my 'a-ha moments', an example being Sonia's use of "Just see the illness" and "put my face on". Here the imagery of two masked people on a dance

floor, together but never connecting, developed the analysis in the direction of the students' developing professional identity.

I developed master theme tables for the three superordinate themes, modelled on Shinebourne's table in Smith et al. (2009, p. 101). An example of one master table from this analysis is depicted below in Table 5.8. Even at this point, the data continued to be re-worked as new insights arose, especially concerning the participants' encounters with experienced RNs and their use of humour. From the master tables I began to look at frequency of participant occurrence. Smith et al. (2009) emphasised in the group level (convergence) analysis, especially with larger sample sizes, the importance of recurrence and the need for individual participant quotes to underpin each theme. Table 5.9 (below) illustrates how each individual's superordinate themes fitted in the group's converged superordinate themes. All students agreed that humour belongs within their practice, yet they had mixed experiences across their clinical placements with RNs, patients and wider members of the multi-disciplinary team.

The patterns across the ten cases fell into three categories: students, students–mentors and students–patients and these were developed (with associated subordinate themes) into the three superordinate themes: the professional journey, the humanity of humour and humour influences and characteristics. There is an interplay and potential overlap between these themes but I felt it necessary to separate them to show the complexity of humour which the students encounter and have to deal with. The relationships between the superordinate and subordinate themes are illustrated in Figure 5.4 below.

It is custom and practice to detail here the shared experience of the participants within each superordinate theme; however, this will be presented in the next chapter to demonstrate the completeness of the story.

Table 5.8: Master table for the superordinate theme, ‘Humour influences and characteristics’, developed from group analysis

Master table for superordinate theme: Humour influences and characteristics	
Subordinate theme 1: <i>Type and functions of humour</i> (participant)	Quote
Humour opportunities (Gaynor)	listening to their sort of funny stories (10.292)
Coping (Gaynor)	humour is a good coping mechanism (9.265)
As a tool (Gaynor)	it's a useful tool for breaking the ice (11.351)
Humour as a key (David)	I use my humour as a tool to ensure that everyone around me is okay; that they can come to me and I use it as a way of opening up dialogue, or opening up a relationship between me and them (4.101–103)
Coping (Kellie)	I think without my sense of humour I would have given up long ago (8:244)
Dark humour (Kellie)	it's nice humour it's not... I have met nurses occasionally that use very dark humour as well (2.52–53)
Types (Kellie)	it wasn't like jokes or anything like that, it was just stuff you were doing (2.47)
Types (Natalie)	Maybe the use of... not jokes... the use of words that stimulate people to laugh and find it funny (4.96–97)
“like a massive red tomato”: relaying information (Natalie)	it's a sort of information delivery sort of thing... in a food challenge (5.122)
Types (Sylvie)	I am a bit clumsy, I am always dropping things and tripping over and things like that (1.26–27)
Releasing the burden (Ethel)	I think it helps me take things easy and I'm able to take one task at a time without maybe too much panicking (1.20-21)
Diffusing difficult situations (Ethel)	I use my humour to diffuse the situations (1.20)
Banter (Sonia)	I've always bantered with her (12.313)
Unlocking: humour as a key (Sonia)	she's still got a piece of her and that's the piece of her, through humour, that's just come out (7.167–168)
Release (Belinda)	probably just know that maybe humour or fun can take out stress while working; can actually... As a nurse, you can actually have fun while working (18.437–438)
Use (Belinda)	Humour is used to create a rapport between the clinician and the patient. Humour can be used to give a message to the patient, but sort of in a nice way (12.289–290)

Subordinate theme 2: <i>Influences on the use of humour</i> (participant)	Quote
Diversity (Laura)	because we do live in such a diverse society, that plays a big part on people's sense of humour (6.137–138)
In the context (Gaynor)	it's about where, it's about the context (12.359)
Gender influence (Natalie)	because you probably wouldn't use the same humour on a male as a female, sort of thing (8.210)
Humour influences (Sylvie)	I think that is really important, not taking yourself really seriously in a clinical setting because, especially as a young person (10.314–315)
Shared cultural framework (Sonia)	but her humour... She's from up North... says she's a 'Yorkshire Lass' (2.54)
Familial influences (Sonia)	My husband's always making me laugh... how he sees things is way different to how I see things (1.11)
Shared cultural framework (Belinda)	I also look, sort to say, at their ethnicity, because sometimes they will not understand my jokes (1.10)
Demographics affecting the use of humour (Belinda)	what I found more interesting: the older patients love the jokes and they enjoy the jokes, unlike the younger patients (1.11)

Table 5.9: Representation of cross-case analysis of themes for all participants

Superordinate theme	Subordinate theme	Laura	Gaynor	David	Kellie	Natalie	Veronica	Sylvie	Ethel	Sonia	Belinda	No. of Yeses
The professional journey	Individuality of humour	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10
	Learning within the clinical setting	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10
	Developing professional identity	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10
Humanity of humour	Reaching out	Yes	Yes	No	No	No	Yes	Yes	No	Yes	Yes	6
	Humanness	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10
Humour influences and characteristics	Type and functions of humour	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	9
	Influences on the use of humour	Yes	Yes	No	No	Yes	No	Yes	No	Yes	Yes	6

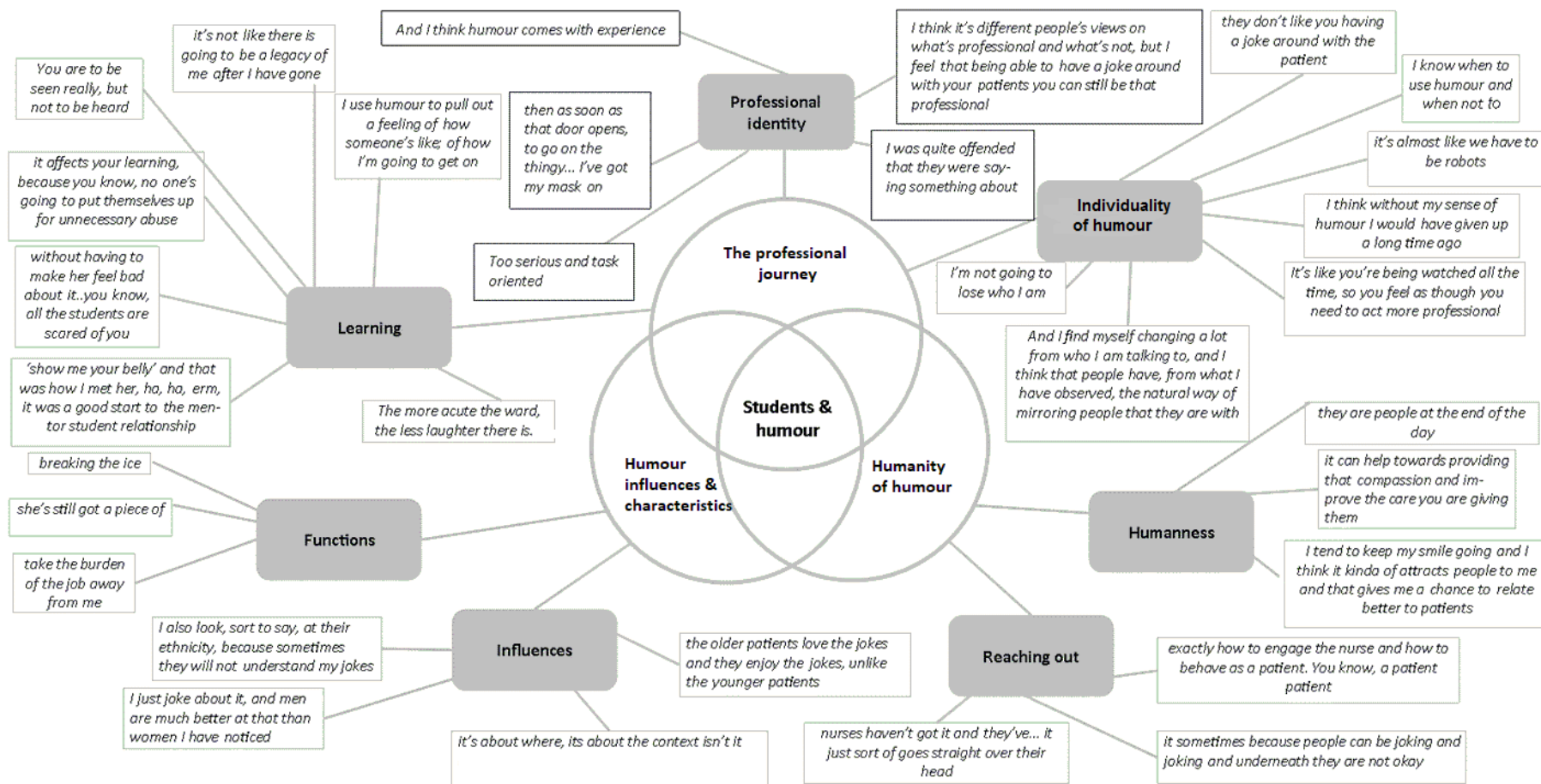


Figure 5.4: Relationship between the themes (adapted from Bennett 2016)

5.13 Chapter conclusions

This chapter has informed the reader of this study's execution and the development of the superordinate themes using an interpretative phenomenological analysis approach. The next chapter presents the idiographical (divergent) biographies of each participant, followed by the details of the convergence within the cross-case analysis.

Chapter 6: Divergent and convergent themes – the findings

This chapter highlights the participants' experiences of humour within the clinical setting which were emergent from the interview process. Firstly, the idiographic biographies of the participants' experiences of humour are presented then followed by the group analysis of convergent themes, leading to the final creation of superordinate themes.

Each superordinate theme with subordinate themes is presented with individual quotes to reflect idiographicity.

6.1 The idiographic (divergent) experiences of humour

The focus of this section is the ten participants' individual experiences of humour in the clinical setting, presented in the order interviewed. Each participant story begins with demographics, the location and length of interview, and a summary of their humour stories. This is followed by a narrative created through their own subordinate themes and associated quotes, building a picture of their experiences of humour in the clinical setting. Each finally concludes with their own definition of humour and a table of their individual themes. See Table 5.2 for an overview of the participants' details. The interviews lasted between 20 and 61 minutes.

All of the nursing student interviewees experienced clinical placements across several trusts, whether acute or community based. Some of these trusts were at the time placed under special measures by the Department of Health or were working on action plans provided by the Care Quality Commission.

6.1.1 Laura

Laura was a 38-year-old, white British woman, married with children, one of whom had a learning difficulty. When interviewed, she was enrolled onto the Adult field course and was in the second of her two second-year placements. She had several years of healthcare experience prior to commencing her nurse education. She was one of the first to volunteer to participate in this study.

Her interview took place within the trust where she was placed for a practice placement and after Laura had completed an early shift. Before and after the interview, Laura and I chatted about her placements as we had a shared history across the various programmes she had undertaken.

Throughout the interview, Laura responded articulately to questions posed. However, she was experiencing a difficult time in her current placement as evidenced by the tone of her voice (quieter), her mentioning her colleagues were not speaking to her, and that she been reprimanded for her humour use, which was documented in her practice assessment document.

Three unique elements of Laura's interview were:

- Her wish to continue using humour and accept the consequences because of its importance to her, despite the tension experienced with some mentors who deemed certain uses of her humour with the patients to be inappropriate
- Her suggestion that the length of time a nurse had been registered impacted on their ability to understand the use, specifically her usage, of humour and that it contributed to the resultant tension experienced
- "Robots" as a metaphor for how nurses behaved in practice.

Laura encased her experiences of humour mostly within patients' narratives, which she portrayed as good and positive, and she demonstrated that she recognised the line of appropriateness as she explained the patients had laughed with her. For example, when a woman required the insertion of a urinary catheter, they joked together as Laura said: "Just lie back and think of England". This is one type of humour she used with sexual undertones, and the other was with a male patient. Both fell under the release humour category, that is, for the purpose of "release of sorts" (McCreddie 2008b, p. 119). She seemed confident in what she was saying regarding her humour use, often increasing her pace of speech when she was recalling a patient or personal experience. It appeared she was willing to take the negative consequences of using her patient-focused humour, as presented in her extract below, when she was chastised for showing a conceived rude Makaton sign to a service user with learning difficulties (release theory, supported by a laugh and was agreed by the audience):

what I had done and was made to feel actually quite bad, like, that I'd done it and said it and... And I didn't let it affect me because I know, from having

my son that you know when he gets to whatever age and he's in hospital and I want nurses to be having that banter with him.

Additionally, she used grammatical intensifiers such as “very” when she wanted to express how strongly she felt or to emphasise the topic we were discussing. She often emphasised the “my” preceding her speaking about her own humour, suggesting the importance of humour to her as an individual.

During the interview, she laughed four times, three of them very heartily, which seemed to be positive as they were in connection with her shortcomings, possibly suggesting she was laughing at herself. These were from the superiority theory as she used humour against herself. However, one was in conjunction with explaining a patient-initiated joke not understood by a RN; this, therefore, could be considered a derogatory laugh. As she furnished no further detail to determine the audience response implicature, it is unknown, although it could be suggested understanding was not reached by the RN.

Across the stories about her humour experiences, it was usually Laura who initiated using humour (4 out of 5 times), often with herself as the butt: “I take the Mickey out of myself” (8:198). According to Laura, the people who did not appreciate her humour were the RNs who had been qualified for a long time; she also thought that they did not realise its importance. This was an issue for her, especially as the mother of someone who has learning difficulties.

The older nurses, the more old school, are very much straight as a die, don't have banter, don't go off the script, as it were.

The tension experienced between her professional role models and her confidence in her own ability to anticipate when, or not, to use humour is evident in the two extracts above. The feeling that a personal tug-of-war existed between Laura and her role models when using humour is apparent there and within the stories she told about her humour use and the RNs' reactions to it. Yet her participation within the social and professional world of nursing was noticeable through her constant use of “we”, even inclusive of herself when discussing “robots”:

Because nurses feel like this... it's almost like we have to be robots. We're not allowed to eat or drink; we're not allowed to talk; we're not allowed to have a joke; erm, we can't possibly have vices, like drinking or smoking or partying and I just think, you know, we're forgetting that they're the very patients that we're treating and we can't possibly understand what our

patients are going through, unless we get into the real world and actually be like our patients.

“Robots” lack the ‘human touch’ and the use of such a metaphor possibly suggests nurses lack emotions and have difficulty in understanding, connecting and building relationships with those they seek to care for.

Laura placed importance on her humour, how it allowed her to connect with people from similar backgrounds and experiences, and how it can be used in patient care, as demonstrated in the extract below:

We should be the ones reminding them of that; not the ones taking it away from them. And if nurses can’t have a sense of humour, then how are our patients going to have a sense of humour. Without a sense of humour, there is no happiness. That’s how I feel.

Laura was my first interviewee in this study and, in hindsight, there were missed opportunities to gain a deeper understanding of what she meant by using the word “robot” for the nursing profession. Throughout the interview she remained steadfast in her humour use, and how this is intrinsic to who she is and the care she provides. Her definition of humour is something that makes people laugh and feel at ease.

Laura’s themes are presented in Table 6.1 below.

Table 6.1: Laura’s themes

Role model tension	“Just lie back and think of England”: recognising the line by using self-control
Shared moments	Humour facets
“The whole package”: holistic approach	Personal tug-of-war
Newer qualified and humour	“Institutionalised: they’ve lost their personality”
“Bridge the gap between the hierarchy” between doctors and nurses	“They’re still allowed to have a sense of humour”: “not the ones [nurses] taking it away from them”: lost sense of humanity
Diversity	Her definition of humour

6.1.2 Gaynor

Gaynor was a 37-year-old, white British woman, married with two children. When interviewed, she was enrolled onto the Adult field course and was in the second of her two second-year placements. Although she had no previous healthcare

experience prior to commencing her nurse education, she had several years of experience in another public service profession.

The interview took place in the trust where she was currently allocated to a practice experience. It occurred during an early shift. Before the interview, we discussed our individual biographies as we had not met each other before. What struck me was her relaxed stance as she had one leg placed on the chair as we sat in the ward's small meeting room.

Gaynor was the only participant who took the provided schedule and systematically worked her way through the questions; it was as if she took control of the interview flow. This did not allow for much probing. Throughout the interview she was relaxed and confident, almost business-like in her answers, demonstrated in the fluidity of speech and analytical approach to the questions posed. Even so, she often vocalised how she struggled to find an example of specific humour within her experience accompanied by her long pauses (2.35 minutes). Of particular note was the number of sighs during the interview. This may be attributed to Gaynor's participation in three other research studies within a six-month period, or her frustration that she could not provide humour narratives. Plus, the volume of Gaynor's voice rose when she was more confident in her answers. She often laughed when discussing herself and her own humour, the loudest outburst being when she talked about how she hoped her answers would be of use to me. At one point she had a laughter outburst when I posed a schedule question, which was not intended to be funny. This could have been a sign of her nervousness.

Three unique elements of Gaynor's interview were:

- Self-limiting of humour use
- Transient nature of student journey and impressions made
- Highly individualistic nature of humour.

Gaynor mentioned two humour narratives involving other people, both of which were more contextual in nature rather than a deliberate instigation of humour by her. Interestingly, these included allied health professionals rather than RNs, a group she struggled to find examples for. Gaynor's laughter about her humour experiences suggests she was positive about them. One experience centred around a mistake

she made because of an assumption that she knew what the procedure entailed (superiority and release theory were applicable here; laughter from herself featured here). The other experience involved a paramedic's faux pas at a patient's bedside, which she and another student found funny (release and incongruous theory and laughter noted). In both situations she makes light of her behaviour, whether about her own learning or taking her reaction to the paramedic to one side, preferably away from the patient as she did in this case. She laughed heartily when describing both incidents but generally seemed reticent to use humour in a professional capacity, yet similarly to Laura she mentioned "robots" in healthcare, and how it does not, and cannot, replace a human being:

despite the inventing of robots that can come in and do sort of health care assistant jobs, you know, we are not robots are we and that's part of, you know, that humour is part of humanity isn't it.

Much of Gaynor's interview centred on self-control (as evident in this quote: "my humour is limited to appropriate use only") as she was conscious of impressions she made on others around her. These impressions made by her, on both the team and patients, formed on the basis that one should "know your audience", due to the individuality of humour and the context one is in, as illustrated by the quote below:

you have to look at the context of the patient as well, what I might find acceptable would be very different to what, you know, my granddad, if he were alive still, would find acceptable and funny or a teenage girl might find offensive or, you know, someone, devout Muslim might find, you know, appropriate or offensive, so, you know, you have to look at your audience don't you, I think, erm, and so that's the issue really, it's about the audience.

As a student, Gaynor was a transient team member and her use of humour was influenced by whom she worked with, as shown in the extract below:

you are going to be influenced by people that you are working with as a student so if someone is very, erm, controlled and very sort of not very animated and quiet, you know, clinical and so in their approach, then that's how they work and it's all, you know, that's how they work and you will probably, I don't mean that's who you will go on when you are fully qualified to be, but for that moment in time while you are with them you won't be doing your good cop, bad cop kind of thing, you will be trying to

sort of, you know, work in a way that compliments them really and then the next day you might be with someone else who is a lot more relaxed.

For Gaynor, humour, especially within the clinical context, is non-offensive and gentle, used as a tool to make people feel at ease but remains highly individualistic. After the interview, Gaynor coined a phrase which has stayed within me since this interview, the phrase coined was “efficacious efficient” which she used to describe nurses she experienced in her clinical placements who were sober in their approach.

Gaynor’s themes are presented in Table 6.2 below.

Table 6.2: Gaynor’s themes

“Are you wearing nail varnish? Let me check your toes sir...”: “know your audience”	Connecting
“We are not robots: humour is part of humanity”	Control of self
“It’s not like there is going to be a legacy of me after I have gone”: transient nature of placements and team integration	In the context
Saving face: learn by laughing at self	Behind closed doors
Individuality of humour	Role model tension
Signalling ‘I’m ok’: team perspective of me	Clinical in their approach
Being vigilant/on guard	Her definition of humour
Humour as a tool	

6.1.3 David

David was a 36-year-old, white British man, in a relationship and had step-children. When interviewed, he was enrolled onto the Adult field course and was in the first of his two third-year placements. He had several years of healthcare experience prior to commencing his nurse education. The interview took place on his day off within the trust where he was predominantly placed for his practice placements.

David was the only male participant within this study. The interview started in a hesitant manner, and there were three points within the interview when he expressed difficulty with the questions, perhaps because of the phrasing or content of the questions, as illustrated below:

This is a difficult question in the sense that... it’s asking... just trying to think, actually. I mean, I think I use it to... as I said, I think I use it to... let’s make this more concise.

Generally, he was soft-spoken throughout. Once he felt confident in giving his answers, he spoke freely and very much owned his opinions through the use of “I think” and “I know”. There was an air of fragility about David, evidenced through the strong emotive words used to describe his feelings of humour and the contrast to his experiences within the clinical setting. He laughed only once during the interview and this was related to a patient story: he seemed genuinely entertained by the memory of the quadriplegic patient instigating humour during a manual removal of faeces.

Three unique elements of David’s interview were:

- His personal investment and conviction in his own use of humour
- Role model tension
- Relational power of humour.

His four humour narratives were predominantly positive, especially those with patients (all involved release theory; humour support was either through laughter or contribution of more humour, noting appreciation and agreement). He instigated humour twice in the stories told and in one the result was him being chastised by a mentor who felt he was inappropriate in his humour use as the patient was terminally ill. He maintained he was confident in his use of humour and gauging when to use it, using the phrase “well aware” to describe his ability to discern the fine lines of humour use. The emotional turmoil of the tension created through being chastised for humour use is expressed below:

I can think of one instance, where I was talking to a gentlemen and his family and we were having quite a good time, laughing and joking around, but she took exception to the fact that... she [mentor] didn’t think it was appropriate to laugh and joke with someone that was so ill, so unwell and we disagreed on it and I told her that it was unfair, basically... but it did make me feel quite reserved and I didn’t want to go in and make jokes with people and I didn’t want to go in and, you know, kind of cheer them up for fear of being seen as someone... fear of treading on other people’s toes and I shouldn’t have felt like that.

David’s belief in the relational power of humour and how it opened avenues of communication in order to understand people, especially the patients, is explicated in the extract below:

without it [humour], I don't think people can relate to each other. It's a form of communication after all, and it's... in order to be able to understand someone, you need to be able to relate to them on a particular level and I think humour in itself, by its very nature is wonderful.

David remained focused on the humanity of the patients throughout much of the interview, and how nurses largely influence their stay in hospital. Although in the excerpt below he demonstrated how he aligns himself with the nursing profession, he seemed resolute this would not be his future practice:

I think, if you've got one person that doesn't find something funny, particularly someone that's in charge, and we forget that these are patients see us, as much as we like it or hate it, they see us as authority figures, and if we can't humanise that a little bit, if we can't bring that human element to it. As opposed to just going to someone to see them like an automaton, like a robot, then that's not right in my personal opinion.

For David, humour is part of who he is. He defined it in positive terms and held that it can be used in various ways, making people feel at ease so that the foundations of a relationship can be built.

David's themes are presented in Table 6.3 below.

Table 6.3: David's themes

Tension with and within self	Mentor–student relationship
Reading the situation	Like a snail
Role model tension	"It's a dark place"
De-humanising	Connectedness
"They're like robots"	Humour as a key
Significance to care	Experience as a nurse (length of time)

6.1.4 Kellie

Kellie was a 23-year-old, white British woman, single with no children. When interviewed, she was enrolled onto the Adult field course and was in the first of her two third-year placements. She had no healthcare experience prior to commencing her nurse education. Kellie was involved in a national campaign to promote the '6Cs' of nursing (care, compassion, communication, courage, commitment and competence) (DH 2012). The interview took place on the campus she was based at.

Before the interview, we had a general chat about ourselves, discussing things such as placements, since I had taught Kellie briefly in her second year. She seemed to take her time to settle into the interview as she had a long pause at the beginning. She spoke softly throughout, often becoming quieter if talking about when she disagrees with someone about her use of humour (for example an RN) or if portraying a negative image of nursing. She chuckled occasionally, especially when she paused or was recalling her current placement. Her loudest laughter outburst was when remembering meeting her pregnant community placement mentor, who had lifted her tunic to show off her abdomen as Kellie walked in on her first day. There seemed to be a lack of certainty in her answers due to the number of discourse markers used.

She recalled several humorous narratives with mixed results. Predominantly those involving the patients were positive, although in one incidence she described laughing at a confused patient (release and incongruous were evident within this narrative; humour support cannot be distinguished). Those involving the RNs were balanced between positive and negative experiences, one of which she instigated and it did not end well. Her humour instigation aimed at the ward's administration staff resulted in reciprocated banter but ended in the nursing staff being called into the ward manager's office and being told to "tone it down". A combination of release, incongruous and superiority theories were applied within her narratives.

Three unique elements of Kellie's interview were:

- Survival
- Student–mentor relationship
- Recognising the line.

Throughout her interview an emerging theme which seemed to be of great importance to Kellie was the need to survive, both in the academic arena and her practice experiences, as illustrated in this quote:

I think without my sense of humour I would have given up a long time ago.

The emotional burden of nursing was a frequent reference within Kellie's narrative as she used humour "to get through the day". Helping students learn to adapt and deal with the daily emotional burdens is part of the RN's role thus assisting in their professional development. This was not always the case in Kellie's experience:

so, I don't know, some nurses quite accept having a sense of humour at work, some of them, I think it gets most people through the day in some cases and others they don't like you having that joke around with the patients; they think it's a bit too unprofessional and... like not how your role as a nurse should be. I have had some people say I am getting too friendly with someone.

When she experienced tension within the student–RN relationship due to her humour use, she felt this impacted on patient care. Kellie also felt it affected her own learning, that a reluctance to use humour could potentially mean losing out on quality learning opportunities:

it makes them [RN] harder to approach I find, if you have got someone that is not very forthcoming and likes to have a bit of a laugh at work, it's very hard to then go up to them and then ask them for something or to do something for you.

Kellie detailed various experiences in which she was of the opinion she can recognise the line of when to use humour or not, as shown below:

if we were in A&E and someone's relative just passed away or someone has just had a very serious traumatic event then you don't really want to use humour at that point, but I think if you have got someone that, say in placement, that has been there two or three months already and getting quite down in themselves, it can help towards providing that compassion and improve the care you are giving them.

Kellie felt humour was difficult to define but it was the simple things which make one giggle.

Kellie's themes are presented in Table 6.4 below.

Table 6.4: Kellie's themes

Survival	Camaraderie
Role model tension	Placement experience
"Tone it down": recognising the line	Student–mentor relationship
Professional journey	"they are people at the end of the day": being human
Dark humour	"Get in the bowl": relating to each other
Types of humour	Taking the time: shared moments
"It [humour] affects the way you treat the patients": influences and impact	

6.1.5 Natalie

Natalie was a 22-year-old, white British woman with no children. She relocated from her home town with her partner to attend university. When interviewed, she was enrolled onto the Child field course and was in the second of her two first-year placements. She had no healthcare experience prior to commencing her nurse education. Her interview took place within the university's main campus, which was different to her base campus.

The conversation before and after the interview focused around what Natalie and her partner thought of where they had moved to. She happily shared with me (someone she had never met before) her experiences of the car breaking down and how she worried about her boyfriend riding a motorbike. She had a cold and had several coughing fits during the interview.

Natalie's interview was characterised by her constant, even-toned responses with only one long pause used (when asked to define humour). Natalie was confident in what she was saying and recalled student and patient stories without hesitation. During the interview she only had three slight laughs.

Three unique elements of Natalie's interview were:

- Creating a caring atmosphere
- Student vulnerability
- Beyond the jokes: seeks understanding of the hidden meaning.

Natalie's experiences of humour often focused on the patients or parents, detailing how she would alter the content of humour to fit her audience. She also used it either to give information or to seek deeper understanding. Natalie mostly gave examples of how to use humour and only depicted herself as an instigator of humour once. One recollection demonstrated her commitment to creating a caring environment, portrayed in the quote below, as she sought to help her RN colleague 'save face' by making a joke of students being scared of her:

she almost got what I was saying without having to make her feel bad about it and just sort of... "you know, all the students are scared of you"

Within this recounted narrative, it seems the incongruity is within the situation as the RN is the role model, not the student. However, it was not always possible to experience this caring atmosphere within the clinical environment when dealing with parents' experiences of nursing care provided:

I think that does a lot [impacts], because I've talked to patients before and they've gone "Oh, don't send that nurse in", sort of thing and obviously, you can tell that that's kind of affected someone, because they're then refusing care from someone who again, might be the best at what they do.

Such experiences place the students in a vulnerable position and Natalie alluded to other situations of vulnerability when a registered staff member adopts an authoritative approach and how this impedes on the student's willingness to access specific learning opportunities:

I would say it affects your learning, because you know, no one's going to put themselves up for unnecessary abuse, so you then don't want to learn from that person, even if they are the best at what they do, or the best in a certain area, so you're then obviously not going to get the best information from the right person.

Natalie's ability to see beyond the words is seen in the quote below:

Or a child that says it to you, like, "Oh, don't make it hurt" or something like that, but the way they say it as a joke, you can kind of develop it further and then kind of say "Oh right, so are you quite scared of me doing it".

Perceived as a gem was Natalie's recollection of a situation in which, through her behaviour, she signalled to senior staff members her disapproval of their inappropriate use of humour; she became the role model:

someone was telling me about this condition and they said how they can't handle people with this condition and I think they then realised that when I didn't laugh about it, that I was quite offended that they were saying something about this condition that wasn't really appropriate in the situation that they were in.

Within this narrative, Natalie is signalling her understanding of the humour; however, she has withheld her support for the humour as she demonstrated her non-appreciation and agreement as she did not agree with the message held within the humour occurrence. For Natalie, humour is individualistic and stimulates people to

laugh; it is not necessarily using jokes but rather how things are said, such as the use of one's tone of voice.

A note of reflexivity is required here as Natalie's insight evoked a maternal feeling within me. I came away from the interview not only feeling protective but proud of this young woman and my association with her as she represents the future of nursing and gives me hope for the profession.

Natalie's themes are presented in Table 6.5 below.

Table 6.5: Natalie's themes

Survival	"No one's going to put themselves up for unnecessary abuse": student vulnerability
Job	Creating a 'caring' atmosphere
Knowing when to (use humour)	Social control
Role model tension	Professional role models
Shared moments	"oh, don't send that nurse in": the compassionless situation
Beyond the jokes: seeks understanding of the hidden meaning	Types
Gender influence	"like a massive red tomato": relaying information

6.1.6 Veronica

Veronica was a 24-year-old, white British woman, single with no children. When interviewed, she was enrolled onto the Adult field course and was in the second of her two second-year placements. She had some healthcare experience prior to commencing her nurse education. Her interview took place on the campus she was based at.

Before the interview, we discussed our individual biographies as we had not yet met. She sat hunched forwards over her chair, looking young and frightened, so I felt I had to 'draw' her out. She gradually settled herself back more fully into the chair to what I considered a more relaxed position. After the interview, Veronica and I sat and had a long conversation about life experiences and fears over ageing grandparents.

Throughout the interview, Veronica spoke softly and, perhaps due to her speech impediment, at a slower, considered pace. In the beginning, she answered in one

sentence answers which became fuller after prompting. She started the interview by saying she knew what she wanted to say, but later corrected herself to the opposite. There were several occasions early on when her laughter was in short bursts, perhaps due to nerves but, by the end, it was quite hearty when she recalled her experiences. Her humour experiences involved examples of both patients' and colleagues' uses of humour. She highlighted how she recognised and appreciated humour but was never the instigator within her narratives. Within her narratives, the incongruity theory was most dominant, with humour support coming from laughter. Similarly to Natalie, she withheld her full support for a humorous occurrence since she did not agree with the sexual connotation held within the incongruous use of humour (below).

In one instance, she detailed how a male carer, after a bed bath, adjusted an older woman's stocking whilst saying, "You've got to get that stairway to heaven sorted out".

Three unique elements of Veronica's interview were:

- The nurses' territory
- Unconsciously choosing
- Patient-initiated humour.

For Veronica, the demarcation of territory and associated power between the nurses and patients arose as an issue when sharing humour, as seen in the following quote:

In a hospital, there seems to be a kind of distance between patients and nurses, whereas I think in the community... because my friend [fellow student] actually said this to me: it's because in a hospital, nurses feel like it's their territory.... And when you have patients, it's like: you do what I tell you to do... Whereas now I'm in the community, it's like the nurses are going into the patient's territory, so it's more like the patient is in control and the patient tells the nurse what to do...it's like a power shift.

This power imbalance continued further with the following quote, emphasising the vulnerability of the patients due to the inescapable effects of being ill, and the emotional impact inappropriate (cynical) humour use can have on the patient:

They [patients] don't want to be brought down too much (5:97-99).

Learning one's craft is done through the role modelling of the expected behaviours by the RNs. When asked to provide explanation of what she meant by being "too clinical" in one's approach, Veronica noted the effect of the non-receptiveness of a nurse to a patient's humour:

if they're talking to you about their day and they say something like... I'm trying to think of an example... [pause] Like, 'too clinical' would just be: if they cracked a joke and you just had a straight face and you didn't really respond to them; like if you were doing their blood pressure and it was up and they were like "Oh, I shouldn't have had that big lunch" and you're just like "you shouldn't have", it wouldn't be very nice. It's just too cold. You'd just be like "Oh, you know, you shouldn't have, but, oh well, you'll know in future.

From role models she experienced, Veronica described how she would unconsciously choose the behaviours observed and how she would self-mould her practice with regards to the use of humour:

Because you're watching them and every nurse that you meet is kind of a role model in a way and then you pick and choose, I don't think consciously, of what you think is the best method [pause]. I wouldn't really look back and think: yeah, I'm trying to be like her, or I'm trying to be like her. You kind [laughs] of find your own way. Especially depending on how patients respond to you.

Laughing heartily at a recalled episode with a patient who constructed his own drip stand from an umbrella and clothes hanger (incongruous theory; support from laughter), the following quote explains how she uses humour within her own clinical practice:

I think you definitely need humour in such difficult circumstances. I've definitely used it all the time, but you wait for the patient to initiate it, because that's more appropriate... And you have to be professional as well.

The connectedness Veronica felt with patients when recalling incidents was emphasised within her interview as her focus continually returned to patients' well-being.

Veronica's definition of humour is that it is a way of bonding with people, ensuring there is no barrier or divide inhibiting the relationship, which in turn leads to openness. By doing this, a person can lift people up.

Veronica's themes are presented in Table 6.6 below.

Table 6.6: Veronica's themes

"You've got to get that stairway to heaven sorted out": recognising/crossing the line	Control/Power (Placement)
On guard (cautious)	Placement experience
The nurses' territory	Factors influencing team
Scary nurses	Pressure
The darkness: cynicism	Trapped: the inescapable effects of being ill
Learning my craft: socialisation	Patient-initiated humour
Unconscious choosing (self-moulding)	Connectedness

6.1.7 Sylvie

Sylvie was a 23-year-old, white British female, single with no children. When interviewed, she was enrolled onto the Adult field course and was in the first of her two third-year placements. She had some healthcare experience prior to commencing her nurse education. Her interview took place on the campus she was based at.

Before the interview started, Sylvie and I, whom I had taught briefly in the first year, had a general conversation. However, the focus shifted quickly to her T-shirt: it displayed a learning difficulty charity logo and she told me of her personal experience of people with learning difficulties. After the interview ended, Sylvie and I continued our conversation about topics arising in the pre-interview chat.

At the beginning of the interview, Sylvie's tone of voice was high pitched and her speech was fast. This, however, settled to softer, slower tones as the interview proceeded, with her only using intermittent elevated tones when talking about patient encounters. During these times she often chuckled, which could have been her nervousness. This was certainly the case another time: when discussing certain colleagues' inability to complete tasks when working together, she talked in a serious tone but had an accompanying nervous laugh. She left several sentences

unfinished, which suggests a mutual understanding of our shared world as I too am a nurse and knew the places she was talking about.

She used the term “I think” 65 times, which demonstrates her ownership of her experiences and opinions. Noticeably, she drew the attention back to herself when discussing how people can connect with her more due to the perception of a common clumsiness. Other repeated phrases were “noticed” and “observed” in connection with her observational skills.

Sylvie described how she made a conscious choice to use humour in her skills repertoire with the patients and recalled how a “grumpy” patient made light of her suggestion he looked like a stormtrooper, minus the helmet, in his cervical collar by getting his son to draw a picture of a stormtrooper. Within her narratives a combination of superiority, incongruous and release theories were applied, with humour support evident in laughter shared. There were two uses of SDH by the patients.

Three unique elements of Sylvie’s interview were:

- Mirroring others
- Power
- Making connections.

Sylvie begins,

I think humour is an incredibly personal thing, it is somebody’s whole personality is based around it.

However, Sylvie’s extract below demonstrates that within the clinical setting you mirror whom you are working with:

And I find myself changing a lot from who I am talking to, and I think that people have, from what I have observed, the natural way of mirroring people that they are with.

So, there is a suggestion that if she mirrors the environment around her, then Sylvie changes something that she felt is intrinsic to her personality in order to survive.

However, it could be suggested that mirroring others increases her resilience, so she becomes a survivor.

An example of Sylvie mirroring those around her arose later in the interview, as she explained in the quote below:

So like when I am with my mentor we are always joking about, it's great, and when I am with one of the nurses who doesn't really joke around, I won't, you know, I will just be doing my work and make sure...I will still joke with the patients because I can't not do that, that's just who I am, I still think that it is a good thing to be smiley and chatty and be jokey with the patient, but I won't do that with her and then when I am with the sister, I don't really speak a lot to be honest, ha, ha, erm, you feel very judged for everything you say, I feel like that.

From Sylvie's perspective (above), she continued to enjoy her humorous relationship with the patients, one she consciously chooses to continue; however, she emphasised the power differential in her relationships with them, evident in the following quote:

because I'm telling people who are old enough to be my gran and old enough to be my mum what to do and that can be really uncomfortable, it can be uncomfortable for everybody involved and with the opposite sex as well; with men as well.

Sylvie felt she has a good rapport with the patients, often speaking about her own ability to connect:

I have noticed that people trust me more I think and I know that's quite a bold statement, but it is just that people have actually said those words to me; "I just really trust you" because I feel like, because I think it's because I spend a bit of time with them when they go...actually chatting about something that isn't to do with medicine, it isn't to do with anything that I have to do immediately right then, it's just a, just a small, you know, just a minute; just a minute of just being another human being with that person.

Her approachability is in contrast to some role models she experienced; she described how patients experience difficulty in speaking to certain staff members with professional and hierarchical status.

Sylvie pondered humour for some time, saying she found it difficult to define, feeling it was contextual and too varied to be specific. However, she did think it contains a dark side.

A note of reflexivity: based on the pre-interview conversation and several pointers within the interview, I felt the need to discuss with Sylvie the concept of ‘too much, too soon’, as a way of conserving her energy and passion for nursing.

Sylvie’s themes are presented in Table 6.7 below.

Table 6.7: Sylvie’s themes

Mirroring others	Influences on team cohesion (includes patient)
Tug of war (professional)	The learning environment
Power associated with role	Joking mentor
Missed opportunities	Making connections
Types of humour	Humour influences

6.1.8 Ethel

Ethel was a 36-year-old, black African woman, married with children. When interviewed, she was enrolled onto the Adult field course and was in the first of her two third-year placements. She had several years of healthcare experience prior to commencing her nurse education. Her interview took place on her base campus.

Before the interview, Ethel and I had a conversation about her progression through the programme as I had taught her in both first and second years and supported students within placements she had experienced. As Ethel and I shared common knowledge of living in an African country, this was a topic we discussed after the interview by swapping stories.

During Ethel’s interview, there was a distinct focus on daily nursing skills such as bed-bathing and performing last offices. She also used “you know” 35 times, suggesting an established shared knowledge of the context between us.

Ethel used long pauses between the question being asked and her answers, often requiring prompts to expand on her answers, or reassurance when she questioned if the answers were right. She laughed quietly for short spells, which suggested she was nervous.

Ethel’s use of “we” 15 times seemed to be in connection with when she was talking about other carers, rather than the RNs. It suggested that she had yet to feel established into the team or the role of the RN.

Her four humour narratives included stories about witnessing two inappropriate uses of humour by colleagues, one using the term “sausage roll” to describe the final preparation of a deceased patient. This, however, could be argued to be an instance of dark humour allowing healthcare professionals to cope with the emotional labour of their daily situation. The other example is when a male colleague, during a bed bath, called a naked, older woman “young woman” when asking her to roll to his side of the bed, where he was standing. She did not signal how she demonstrated her non-appreciation of these experiences. The other two narratives described how she used a light-hearted manner to diffuse potential conflict situations (for example, racial tension).

Three unique elements of Ethel’s interview were:

- Coping
- Pressure
- Openness, showing approachability.

Ethel used humour to cope by releasing the burden which she feels when working, as illustrated in the quote below:

it [humour] helps me maybe take the burden of the job away from me.

Furthermore, she describes the pressure felt also by the non-humorous RNs and how this impacts on her as a student nurse, as illustrated in the first quote below, and in the second quote explores the emotional impact of not using humour to cope or alleviate the pressure.

So sometimes you even... like, I could be waiting to tell a nurse something, but they’re too busy, you know. It’s kind of switching off to somebody who really needs them, especially us students.

because if you get too focussed with the job, then you know, all your might is like straight to the job and you’re forgetting to be sometimes yourself, if you feel like a humorous person; you’re not using that maybe to help you in the job.

Across the interview, Ethel mentions an approach adopted that she calls “open face”, which signals her approachability, and how this impacts on patient care. It is through

this openness and approachability that humour allows a negotiation between nurse and patient in the care relationship, as depicted below:

Because I always find if you're a bit humorous or approachable, patients are always willing to work with you, or, you know, they open up more to you, whereas if you're too busy with a serious face, it can be a put off to the patient.

Finally, for Ethel, humour is having a bit of laugh as long as it is appropriate to the clinical setting.

Ethel's themes are presented in Table 6.8 below.

Table 6.8: Ethel's themes

Allows you to go the extra mile (making a difference)	Not focused on students
"Oh, come on, let's go and do the sausage roll": recognising the line	Teamwork: internal and external influences
Role model tension	"Come on, come give me a hug": negotiation between nurse and patient
Coping	Openness: showing approachability
Pressure	Diffusing difficult situations
Releasing the burden	Placement differences

6.1.9 Sonia

Sonia was a 52-year-old, black Caribbean woman, married with children. When interviewed, she was enrolled onto the Adult field course and was in the first of her two third-year placements. She had several years of healthcare experience prior to commencing her nurse education. Her interview took place in the campus nearest her house, which is not her base campus.

Sonia was the participant I knew well, due to teaching commitments with her cohort and placement support sessions, so prior to the interview we had a general conversation about how quickly time had passed as she was nearing her goal of becoming an RN. There was a general ease in the conversation especially noted in her reply to my question of how she felt when I giggled at one of her stories: her reply was that I understood where she was coming from and could feel the situation; this signified the shared world of nursing of which we are both a part. Several terms used by Sonia indicated our connectedness within the nursing world: she used "you

know” 52 times; “you see” or “you see what I mean” four times; and just called apparatus “thingy”, knowing that I would understand.

There were several examples of personal humorous episodes with the patients, often accompanied by a giggle or a lighter tone in her voice. The four patient-orientated humour narratives were mainly of the patients instigating the humour, with Sonia playing along or echoing them. In all four narratives, incongruous theory was evident. Recalled humorous episodes with her colleagues focused more of the functionality of humour, such as coping. She laughed heartily throughout the interview, especially in an example in which a patient called Sonia over and said she had “a pea in her bum”. Rather than dismissing it under the premise the woman was confused, Sonia asked her permission to investigate by looking under the blankets, revealing a pea stuck in the crevices of the patient’s buttocks.

Sonia spoke in an even-paced tone and used high-pitched emphasis on the light-hearted things, such as “happy hat” used to describe her adopted attitude at the beginning of the shift, to ensure nothing bad happens during it.

Three unique elements of Sonia’s interview were:

- “Being a patient patient”
- Behind closed doors
- Masks.

Within the ED, her current placement, Sonia described her experience with a patient suffering an acute asthma attack and how the patient used humour to ensure she received care, as illustrated below:

the first thing she resorted to was humour. ‘I’ve got to make her laugh.’ I don’t know if it was because: ‘I’ve got to make her like me, so she can give me a bit of treatment’... But it’s that kind of thing that I found; that she was just straight in there. Like, she knew exactly what to say; exactly how to engage the nurse and how to behave as a patient. You know, a patient patient.

Sonia offered two interesting insights: she regarded it as the patient’s job to recover and she looked for humour as a sign of their recovery.

Sonia mentioned “the mask” nine times in the interview and, from the quote below, it suggested nurses put on a performance of professionalism for the patients by making the right impression:

Because they’ve got this intense mask; this iron mask on. “You know, I don’t smile and I... You are going to look at me and you’re going to see me as this person who does this job. I don’t fraternise with... I don’t engage in other things, other than what my job is. That’s it.

She implied illness shades the person in times of urgency:

I just need to get the immediate situation sorted, so that I can see the person, because all I can see in an acute situation is the illness and that’s the truth. I can’t see the person yet... I can only see the illness and I need to get rid of that illness so that I can see the person.

Drawing from Sonia’s suggestion, illness can ‘mask’ the patient from the nurses in the immediacy of the situation. If the nurses concerned are wearing a professional (non-humorous) mask also, then this leads to a strong visual metaphor of two masked dancers dancing, but never connecting. Humour itself has been known to be used as a mask in certain situations; however, humour can also play a part in breaking both types of masks.

Sonia had contrasting experiences of humour. She described how in the ED it occurred within the public facing areas, using the staff room for quiet contemplation, whereas in the general wards, likened to a “morgue”, humour occurs away from public view, behind closed doors:

So as soon as that guard goes down, like I said, when they’re having their lunch, or they’ve read something, the caterwauling and the noise that comes out of the staff room when they’re having... is amazing and then as soon as that door opens, to go on the thingy... I’ve got my mask on.

She felt strongly about humour being an intrinsic part of her and how it impacts on the impression she wants to leave behind. For Sonia, humour was about positivity and using it to help one see things differently, through the form of gentle banter to save one’s dignity or to feel connected.

Sonia’s themes are presented in Table 6.9 below.

Table 6.9: Sonia's themes

Self-discovery	Can make mistakes
Beyond empathy (compassion)	Sign of recovery (from illness)
Other-esteem: need for validation of care	Placement experience
Knowing when to...	Role modelling
Fractioning the entity	Behind closed doors
Personal expectation of self	Coping Time
Role model tension	Experience of mentors
Feeling safe	Using humour to attract nurses' attention
Being a "patient patient"	"I am here": discovering me
Being linked	Shared cultural framework
Unlocking: humour as a key	Familial influences
Banter	Masks
The professional	Time
Age	Can make mistakes
Urgency of the situation	Development of 'my' knowledge

6.1.10 Belinda

Belinda was a 31-year-old, black African woman, married with two children. She had returned to the programme from an absence due to maternity leave. When interviewed, she was enrolled onto the Adult field course and was in the first of her two second-year placements. She had some healthcare experience prior to commencing her nurse education. Her interview took place in her base campus. This was my last participant interview and was one of the longest.

Although Belinda had just returned from maternity leave, I knew her because of previous teaching commitments and placement-support sessions. Prior to the interview commencing, our conversation focused on her new baby and about her return to the programme.

My impression of Belinda was one of an assured and confident woman and yet, at the beginning of interview, my response to her first answer was one of surprise as she said she used humour reservedly.

Throughout the interview, Belinda talked mostly at a constant pace and level tone, only raising her tone for emphasis or laughing at patient stories. On the occasions when her pace increased (for example, telling of a patient story), her language usage became muddled but was still understandable within the context. As English is not

Belinda's first language she often used words in the literal form, such as, "if a team is free together" (this was interpreted as meaning when a team is open with each other). Another term used 20 times, and in many different situations, was "cold"; these uses are interpreted within the context of the situation. She used "we" 46 times, inclusive of when talking about students, nurses, her African origins and the ward team, so it appeared that she felt part of all these groups.

There were positive and negative examples of humour use with both patients and staff. Belinda was the only participant to recall a humorous episode between herself and a patient, one that she instigated, that resulted in a complaint from a bystander (another patient). Another example given was when a doctor, away from the bedside, made the patient the butt of the joke and she felt as an insider: "It was funny [smiles]. All of us laughed, but because we understand".

Within her six humour stories, a combination of superiority, incongruous and release theory was evident. The humour support implicature noted were laughter, playing along and echoing humour. There was one incidence of understanding of humour but full support was not given as appreciation and agreement were withheld (discussed in 7.1.2).

Three unique elements of Belinda's interview were:

- Ethnicity
- Mentor–student relationship
- "Memories of uniqueness".

On answering the first question ("how would you describe how you use your sense of humour in the clinical setting?"), Belinda automatically divided her own use of humour within the clinical setting into two categories: patient and staff. In addition, two external factors influenced her usage: age and ethnicity. These remained consistent throughout her narrative.

She explained how ethnicity plays a role in her judgement of when to use humour:

race is also very... plays a big role in humour.

Although she used the word "race", she goes on to speak mainly of ethnicity in the form of cultures, for example Asian, English or French. At various points in her

interview, she explained how interacting with various nationalities on a humorous level may be difficult due to her lack of cultural exposure.

For a nursing student, the primary function of a placement is to learn what the role of the nurse is, and learning from others is integral to a student nurse's experience. For Belinda, learning from role models had included surprise and disappointment, as illustrated below:

Me learning, with the person who is cold, it would be very inhibitive.

And,

[I felt] Good. Very good, in fact, very good. I enjoyed it. Because, as I say, she was not as cold and reserved. She... Probably, because she [RN] enjoyed what she was doing and she was... She was open; she had an open spirit; she was... She would really make fun of things you didn't even think about, she would make fun out of it. Like what do you call...? You know, the...? The thing we push, so that the patient can turn around [Rotastand]?

She described several examples from her placement mentors, using the word "cold" to denote their approachability and how this influenced her ability to use humour. In the quotes above, Belinda emphasised the importance of the role models, the mentor–student relationship and how humour usage can influence the student's learning. Further in her narrative about the role model encountered in the last quote above, Belinda highlighted how this extends into patient care:

She had a good rapport with the patients. The patients knew how she knew the patients and because those patients are really sometimes very low in spirit, um, down, they've been through a lot, you as a healthcare professional, as a nurse, is to support them. Go through this journey and when you see them back, most of them... they never want to see another nurse do their chemo; they want that same nurse. I would hear them say "Is [name] around?" Or "Is this person around?" They would like to have that same person because of the memories of the uniqueness that they have whilst giving that care.

It is suggested here the "memories of uniqueness" are the memories left with the patient about their experiences of care received, especially the connection between the nurse and patient.

These role models assist students in developing their professional identity within their own professional group and the wider allied health professionals. Through her

narrative and by using the term “on par” to describe working alongside her nursing colleagues, it was apparent that Belinda felt part of the nursing teams she had worked in. Concerning the wider team, she recounted a tale of a doctor’s quick quip during a ward round and how this had assisted to “break down barriers” between the interprofessional groups (superiority theory was seen here, as it was derogatory to the patient, but release theory was present also as it gave release for the junior staff on the ward round; support was given in laughter). This depicts the potential for humour to act as a cohesive agent across the nursing and wider healthcare team.

Belinda’s definition of humour is that it is a trigger of mood used as a mode of communication to cheer up a patient or to give them information in a considerate manner.

Belinda’s themes are presented in Table 6.10 below.

Table 6.10: Belinda’s themes

Judge the situation	Mentor–student relationship
Being on guard due to own experience	Challenges of learning
Allowing yourself to join in	Factors influencing the environment
Not being myself	Experience as a nurse
Professional expectation and tension	Working as a team
Professional tugs	Putting out feelers
Unpopular patient: being watched	Patient reaching out
Perceptions of culture	Shared moments
Professional role models	“Memories of the uniqueness”
“Allowed to use?”	Use
Power	Release
Hierarchy	Demographics affecting the use of humour
Feels part of the nursing team: establishing professional identity?	Shared cultural framework

6.2 The convergent themes from the participants’ narratives: the superordinate themes

The art of a novice researcher is to ensure an interpretive stance rather than a descriptive one is adopted; however, a balance must be struck between the two to ensure that the interpretation remains embedded within the participants’ narratives. A point of consideration from hermeneutics within IPA, argued by Smith et al. (2009),

is the disagreement between Gadamer and Schleiermacher's work on whether a researcher can, through interpretation, better determine the original author's intention. Smith et al. concluded a researcher can offer insight and perhaps exceed the original author's claims due to a questioning stance from a wider viewpoint across a large dataset.

The next point to consider is the definition of convergence, drawing on Dickson et al.'s (2007) categorisation of recurrent: "the same themes appear(ed) in at least half of the other transcripts" (p. 855). Thus, superordinate themes were established and selected individual quotes, representative of the participants, are found within each of these themes. The majority of these are presented as outlined by Smith et al. (2009) and Flowers and Dickson (2017): a generic description incorporating three idiographic quotes which best illustrate the subordinate/superordinate theme.

At this point, there is a need to consider the humour stories narrated, for the 45, fully described, humour occurrences from the participants' interviews contained examples of student–patient and student–role model interactions. Using McCreddie's (2008b) distinction between problematic and non-problematic humour, the following classifications occurred:

- 31 student–patient interactions used non-problematic humour
- three student–patient interactions used problematic humour.

Moving onto the student–role model interactions:

- seven were considered as using non-problematic humour
- nine were considered to be using problematic humour.

From the students recalling RNs' use of humour with patients:

- four were considered to be using problematic humour.

There were incidences of the participants of recalling positive influences of role models use of humour but these were not contained within a fuller story.

Following IPA, three superordinate themes arose in each participant's journey. These superordinate themes and the patterns of ideas across the participants are the focus of this section (see Table 6.11 below). Although the three superordinate themes (with their subordinated themes) are presented separately within this section, they are interlinked. At the end of each section, key findings across the theme are presented.

Table 6.11: Super- and subordinate themes

Superordinate theme	Subordinate themes
The professional journey	The individuality of humour
	Learning within the clinical setting: relationships and environment
	Developing professional identity
The humanity of humour	Reaching out: I am here
	Humanness: connected through uniqueness
Humour influences and characteristics	Type and functions of humour
	Influences on the use of humour

6.2.1 The professional journey

The findings described in this section highlight the student's professional journey, beginning with the value they place on humour and how they feel they are able to judge when to use humour. This is followed by the learning they experience within the clinical setting and the subsequent influence on their learning of the student–mentor relationship. Finally, this section considers the negotiation of their professional identity and the influence RNs, through their use of humour, have on the student participants' development.

6.2.1.1 The individuality of humour

The findings illustrate specifically how participants and their acknowledgement of the individuality of humour reflect their personality, and how they can be embroiled in a tug-of-war with the people around them on the use of humour within the clinical setting. Findings show how the participants own perceived humour boundaries are associated with their own values and interwoven into their use of humour.

Overall, the importance of humour was expressed by five participants, three of whom were the most senior participants involved in this study. The strength of their convictions was best voiced by Sylvie in the following quote:

I think humour is an incredibly personal thing, it is somebody's whole personality is based around it (3:70–71).

Here Sylvie spoke of humour as being an integral part of oneself; this emphasises its value to the individual and how it filters through one's being on an emotional, cognitive and social level. As humour is integral to oneself, this demonstrates the participants' pre-existing capacity of humour prior to entry to their nursing programme. This awareness of their pre-existing capacity for humour often underpinned their judgement of when to use humour. All participants were adamant that they could decide when *their* use of humour was appropriate, best encapsulated in Veronica's quote:

You can tell by a person's... the way they're holding themselves; if they're not in the mood, then you're not going to try and push it (3:67–68).

Veronica's quote highlights her ability to interpret a person's humour receptivity within the situation and how she makes a conscious decision not to overstep any boundaries. All interviewed participants felt that they had the self-awareness and confidence to recognise the boundary between appropriate and inappropriate use of humour. If humour is considered to be a part of personality, it suggests the importance of recognising the boundary between appropriate and inappropriate humour is underpinned by an individual's value set.

A sense of mistrust, by the mentor, of the participants' ability to judge when to use humour was the most frequently reported experience, as illustrated in David's quote:

I can think of one instance, where I was talking to a gentlemen and his family and we were having quite a good time, laughing and joking around, but she [mentor] took exception to the fact that... she didn't think it was appropriate to laugh and joke with someone that was so ill, so unwell and we disagreed on it and I told her that it was unfair, basicallybut it did make me feel quite reserved and I didn't wasn't to go in and make jokes with people and I didn't want to go in and, you know, kind of cheer them up for fear of being seen as someone... fear of treading on other people's toes and I shouldn't have felt like that (3:80–88).

David's feeling of utter anguish is evident in this quote, as he recalled this to be one of his most precious moments in his career to date. This highlights not only differing opinions on the use of humour but also the external influences impacting on the participants' practice and the emotional cost. The resultant tension, due to differing opinions over the timing and appropriateness of humour used, seemed to develop into a tug-of-war scenario between the participants and some of the RNs. This could undermine the participants' self-confidence. Some interpreted this tension as an attack on them personally, especially if they believed humour is integral to who they are, as depicted in Laura's account:

Yes, I'm a nurse and I know I'm a good nurse and I will make a good nurse, but I'm not going to lose who I am; I'm not going to lose my own personality, which is being a bit goofy and cracking a few jokes and sometimes being a bit rude about it, but that's who I am and I'm not going to lose that just because I'm a nurse and that's what I try and remind my colleagues whenever I can (9:212–215).

Laura's frustration over the feeling that she needed to abandon her personality is clear in the quote above. Many participants, like Laura, felt a sense of losing their identity when not being allowed to use humour, which is a high emotional price to pay. From this tension, a sense of being watched or judged arose for the participants and the need to adapt to whom they were working with. The following quote from Veronica best represents those feelings:

It's like you're being watched all the time, so you feel as though you need to act more professional, which you do really. Especially, because you have to be professional to the patient [in hospital] (9:202–203).

Veronica's experience here highlights that because 'big brother' is watching there is an over-emphasis on professional behaviours, especially in terms of professional and patient expectations. This quote shows the guardedness adopted by some participants, a sense of self-protection. This felt need for self-protection can result in unconsciously trying to fit in, as depicted in several participants' accounts of adapting their behaviour to whom they were working with, and where, as illustrated in Sylvie's quote:

And I find myself changing a lot from who I am talking to, and I think that people have, from what I have observed, the natural way of mirroring people that they are with (6:179–180).

Not being allowed to feel oneself led to tensions within the student, potentially because it could result in an insincere representation of their self, which could affect their relationships with others. The experienced disconnect between the participant's use of humour and the expectation to replicate others' humour behaviours could lead to emotional distancing in order for them to cope, which may impact on their ability to deliver compassionate care. This has the potential to emotionally exhaust the participants if sustained over long periods of time.

The gem (a phrase with significance, Smith et al. 2009) within this section came from Sonia:

So you kind of want to get that person to a point where you can talk to them to make you feel better that that person's okay... And if you can banter with that person as a humorous escape, as we were, with the woman with the catheter, it makes you feel that you've done your job better (5.107–109).

In Sonia's account, the patient's use of humour was used as a recovery marker and she offered a viewpoint that the patient's recovery validates her accomplishments as a caregiver which promotes her self-esteem. However, linking the patient's recovery to one's own emotional well-being and competence can be fraught with uncertainty, due to the unpredictability of a person's health.

Key findings

- Participants perceived that their pre-existing capacity for humour reflects their personality and are unwilling to lose it
- Participants believed that they are able to judge when, or when not, to use humour
- Conflict can arise for the participants if the RN disagrees with their judgement of when to use humour, or if a role model's humour use conflicts with the participant's values
- The participants adapted to whom they are working with, regarding humour use, which puts them on guard
- Emotional energy is expended through the additional stressor of not being allowed to use humour
- Linking one's emotional well-being and competence to the patient's recovery is fraught with uncertainty.

6.2.1.2 Learning within the clinical setting: relationships and environment

These findings demonstrate that the student's learning within the clinical environment is affected by certain factors, namely the relationships formed within the clinical setting team and learning accessed during the practice placement.

Students are transient during the clinical component of their education (NMC 2010); this meant a placement change at least twice a year for the interviewed participants. These participants experienced a combination of hospital (acute) and community placements and the most commonly reported experience within the narratives was the humour differential between these, as depicted in Sonia's extract:

The more acute the ward, the less laughter there is... (8.188)... I feel... because when I used to go on to their wards and it was like, sometimes it was like walking into a morgue (9.211–212).

A morgue is usually associated with death, clinical sterility and stillness, a place of no humour. Sonia's sentiment about the wards being an area of no humour was shared across several participants, dependent on with whom they were interacting. There was a clear sense of resolve amongst several participants that, irrespective of

their placement, they would continue using humour (especially with patients) and, for some, to do so regardless of the consequences.

Within the acute sector, there was a humour difference amongst the specialisms such as the emergency department (ED). It was felt by some of the participants that here they were able to make a mistake, due to a flattened hierarchy, as depicted in Sonia's quote:

I think [ED] is quite a good place for humour, because I think they use that as a coping mechanism, including because there is no real hierarchy of people, everybody just banter and just talks about whatever and they just say whatever they say and if you make a mistake, it's not classed as a 'mistake' (8:199–204).

The community setting is another clinical setting which has a flattened hierarchy, due to the autonomous nature of the work. It is within this setting that a student nurse will spend the majority of the time on a one-to-one basis. Students expressed that the community settings were more humorous in nature, often describing them in a light-hearted manner with a smile on their face, including stories of both the RNs (district nurses) and patients. The notion of the humour differential within the community setting is supported by Veronica's quote:

it's because in a hospital, nurses feel like it's their territory...Whereas now I'm in the community, it's like the nurses are going into the patient's territory, so it's more like the patient is in control and the patient tells the nurse what to do (8:170–171)...You feel more human [laughs] in the community (8:185).

Veronica's use of the word "territory" implies power and boundaries. Her emphasis on the nurse entering into the patient's territory signals that the power lies with the patient; if a patient initiates humour, then it is more likely to be reciprocated by the nurses. Emphasising that the community's placement makes the student feel more human, a point that links with the next section, highlights the participants' experiences of the acute sector as being almost robotic, lacking in relational skills and only focusing on the 'task'.

The power differential extended into the mentor–student relationship and was evident in several narratives. There were varied experiences amongst the

participants, who highlighted the subsequent effect on the learning relationship, as demonstrated in two of Natalie's quotes. This is the first:

probably when it's at other people's expense as well, 'cos I know there's a couple of nurses that have been like: "Oh, that's all you do" sort of thing and have a little laugh about (6.137–138).

The RNs' intention here, in Natalie's experience, was to question the student's clinical ability based on the stage of her training – this can affect the student's confidence in their own ability. The quote signals it is the intent to belittle which places the student in a vulnerable position, since the mentor's use of sarcasm can be attributed to his/her need to denigrate the student, in line with the superiority humour theory in which the intent is to mock. The laughter described within this experience supports the potential for laughter to be used in several different ways as it indicates that the mentor is laughing at the student, rather than with the student. This demonstrates the power dynamics within the relationship: the mentor, as assessor, has the legitimate authority over the student and their learning (Burns 2015). The student's vulnerability, based on a power dynamic, was a common thread through several narratives, eliciting feelings from despair to being infantilised. A consequence of such humour use by mentors was the limiting of the students' access to learning opportunities, as seen in the second quote from Natalie:

I would say it affects your learning, because you know, no one's going to put themselves up for unnecessary abuse, so you then don't want to learn from that person, even if they are the best at what they do, or the best in a certain area, so you're then obviously not going to get the best information from the right person (6.152–156).

Using the word "abuse" demonstrates the intensity of the power dynamic as perceived by the students. Conversely, the positivity of mentor–student relationship is represented in Kellie's quote:

the first time I ever met her was when she walked into a room, lifted up her tunic and someone asked me, someone shouted 'show me your belly' and that was how I met her, ha, ha, ha, erm, it was a good start to the mentor–student relationship we had (10.298–301).

This illustrates the common ground of trust and respect between Kellie and her mentor, one which enhanced this student's feeling of belonging; this was replicated

for the participants with varying success within the nursing and wider multi-disciplinary teams (MDT).

Several participants described situations where the use of humour bridged the gap in both vertical and horizontal power relationships, within the nursing team and the MDT, making them feel more of a team member. This created an open and welcoming learning atmosphere for the participants that motivated their learning. They expressed that in connecting with whom they are working (either by accepting the individuality of humour within the team or the feeling of 'we all in it together') they felt humour acted as a communication tool amongst colleagues which created a shared understanding, thus facilitating group solidarity.

Key findings

- Participants experienced a humour differential in their role models' use of humour, dependent on the type of practice placement (acute or community)
- The mentor–student relationship has the potential to place students into a position of vulnerability, which can limit learning opportunities
- Learning is more likely to occur if a positive mentor–student relationship exists, enhanced through a mutual use of humour, as a sense of belonging for the participant is established
- Humour can enhance the learning environment
- Participants recognised how humour can motivate a team.

6.2.1.3 Developing professional identity

These findings illuminate the participants' experiences of their role models' professional expectations of them and their use of humour, including: the role modelling of humour use by RNs; humour as a mask for the nurse; and the influence that the age and experience of the role model may have on the use of humour within the clinical setting.

There was a clear sense of differing definitions of professionalism among all of the participants as encapsulated in Kellie's experience:

I think it's different people's views [RNs and student nurses] on what's professional and what's not, but I feel that being able to have a joke around with your patients you can still be that professional (4.131–133).

This quote highlights the individualistic definitions of professionalism from both the RN and the participant as a student nurse. Across all participants' experiences, there was a shared understanding of a tension of being 'on edge' when they had a different definition of professionalism regarding the use of humour to that of the RNs working alongside them. This could make it difficult for the student to achieve individual RN's professional expectations of them; balancing tripartite (personal, public and professional – NMC and individual RNs) expectations of what it is to be a nurse is stressful.

Individual professional expectations of their role models from the participants are explicated in Laura's extract below since she indicated not only how strongly that she feels humour should be used in clinical care, especially with patients, but how nurses' non-inclusion of humour in their care robs patients of an element of themselves or their humanity:

We should be the ones reminding them of that [sense of humour]; not the ones taking it away from them. And if nurses can't have a sense of humour, then how are our patients going to have a sense of humour. Without a sense of humour, there is no happiness. That's how I feel (7.158–160).

Being robbed of one's humanity equates to being a robot. "Robot" was used as a metaphor in several participants' accounts to describe the automated execution of care by some of the RNs encountered along the students' socialisation journey. Additionally, a robot lacks human emotional capacities such as compassion, or empathy. David's quote is a typical account of this frequently mentioned experience:

They perform the function, but they don't do their job and what I mean by that is: they don't... They're like robots; there's no sort of human element to it a lot of the time and they just... it's kind of like ... there's no sort of thought to the patient and I've seen the way they talk to the patients and they don't.... they may not realise they're doing it, but they don't look at the patient as a patient; it's always 'bed one, or bed two or bed six' and

they... to the point, they just go in and do the IVs; they don't even really acknowledge the patient; they say "Hi", do the drip, walk out (8:213–216).

Here, David's emphasis was on the de-humanisation of both the RN and the patient. Depersonalisation is the penultimate stage of emotional burnout (Talbot and Lumden 2000). This potentially unconscious role-modelled behaviour was evident in the majority of the participants' accounts. There could be a sense of fear: this may be their future. This emphasises a dissonance between the ideal and the realities of the clinical world based on the students' own personal and professional expectations of the kind of nurse that they want to be, in addition to the public's and NMC's expectations of the kind of nurse they should be.

A further discord, adding to the dissonance, was the use of dark or cynical humour, as demonstrated in Veronica's quote:

Like a lot of nurses are really cynical, so they'll have a really cynical sense of humour. But you have to stay positive, because people are there to try and get better... They [patients] don't want to be brought down too much (5.96–98).

Veronica believed that it is the patients who ultimately pay the emotional price for the nurses' use of cynical humour. Additionally, patients do not intentionally seek out people who cause them emotional harm; therefore, this further compromises patient care as these RNs may be judged as being unapproachable. One consequence of this could be the patient not communicating a deterioration of their symptoms. This may also cause the students an ethical dilemma due to the professional expectation of non-maleficence: nurses are expected to minimise/avoid harm to their patients as part of the patient safety agenda, which includes a person's physical and emotional well-being, but these participants, as student nurses, are exposed to role models' behaviours which potentially impact on a patient/service user's emotional well-being, as evident in the last sentence of Veronica's quote.

As the majority of patient care occurs at the bedside, it would seem spatiality played a role in the use of humour. For several participants, professionalism, as role modelled, was deemed a mask or seen as a performance to be used at the patient's bedside; therefore, the patients should not see nurses laughing. This is illustrated in Sonia's quote:

So as soon as that guard goes down, like I said, when they're having their lunch, or they've read something, the caterwauling and the noise that comes out of the staff room when they're having... is amazing and then as soon as that door opens, to go on the thingy [ward]... I've got my mask on (10.244–247).

Sonia here stressed two points. Firstly, in her experience, some RNs will only use humour in spaces away from the patient's/visitor's sightline. Some participants had similar experiences and it seemed to them that these RNs, by exercising self-control, held back a piece of themselves. The other point was RNs using professionalism as a mask, which shares a commonality with the previous point: whether masked or only using humour away from the patients, the RNs held back a piece of themselves. It would seem that the students were trapped in a dichotomy of RNs exhibiting both caring (see 6.2.2) and less caring behaviours along the students' professional socialisation journey.

Natalie highlighted the fact that student nurses do indeed use multiple role models to assist them in developing their professional identities, as captured in the quote below:

you're going to hear them say stuff and you'll then take that on board and then you'll know that that sort of thing's allowed within the practice and you'll sort of think: oh, that was a good way of actually dealing with that situation, so I'll take that on board and then I'll use that (3.77–79).

In this quote, Natalie stressed her observation of the RNs and how she selected certain behaviours to enhance her own professional practice, based on what she observed as being permissible in practice. This could place the student nurse in a quandary: if he/she observes the RN's use of humour similar to those above (for example, as David observed) and it goes unchallenged, then they may decide such behaviour is allowed within clinical practice. Role models are pivotal in embedding passion and compassion for nursing which, in turn, empowers the student on their professional journey. It seems from the narratives that certain role models became barriers on this journey, adding stressors onto the students, either by disagreeing over the use of humour or role modelling humour behaviour in contradiction with what the participants held humour to be and the positivity they ascribed to it. This

suggests that poor role models, and the associated conflict, expend student nurses' emotional energy.

The standalone point below is Natalie's gem. The section above has presented the role modelling behaviours around the RN's use of humour and how the participants, as student nurses, were exposed to these as part of their professional journey and development of their professional identity. Conversely, in Natalie's quote below, she demonstrated how she developed the RN's professional identity:

someone was telling me about this condition and they [RN] said how they can't handle people with this condition and I think they then realised that when I didn't laugh about it, that I was quite offended that they were saying something about this condition that wasn't really appropriate in the situation that they were (2.38–41).

With this quote, Natalie's (a first-year student, 22 years old) use of personal agency, by not laughing (not showing appreciation) and her non-agreement to the humorous content, demonstrated to her role model their inappropriate use of humour. Therefore, she used her non-humour as a form of social control. Arguably, it is the learner who became the role model/teacher. Her use of the intensifier "quite" indicates her level of indignation; this potentially would affect the learner–teacher relationship within the clinical setting.

The participants' experiences of how chronological age or length of experience affected the humour use of their role models varied greatly, with no consensus. Many of the participants, based on their clinical experiences involving numerous role models, had views on how they thought age and experience would affect humour use. For some, they thought it would be the newly RN, still exuberant from reaching their goal and energetic in their first job, who would use humour more within their clinical practice, as detailed by David in his quote:

Not all of them; I've seen a few nurses in the acute placement that really are wonderful and they use humour and they laugh... Particularly at Sister level... I've noticed that, interestingly enough, because I thought it would be the other way around; people that are newly qualified and newly gone into it would be able to make much more light of it; to be more energetic, but no. If anything, it's the other way around (8.200–204).

Here, David's experiences proved his assumptions wrong. It would seem, in his experience, the newly RNs are too unsure of their own practice, so they concentrate on doing things by the book. David concluded it is the more experienced nurses, confident in their own practice, who are the frequent users of humour. His conclusion rested on the further assumption that advanced communication techniques are attained through years of clinical experience.

Laura, in her experience, offered a contrasting viewpoint as illustrated in the quote below:

The older nurses, the more old school, are very much straight as a die, don't have banter, don't go off the script, as it were (2.42–43)... I think they've been in the job too long and I think they've lost their personality. I think they've lost who they are, because they've been in a system that really doesn't allow for humour; it doesn't allow for nurses to have a personality (3.59–61).

In Laura's quote, it would seem the more experienced nurses (generally considered to be the older ones) become more jaded and humourless with each passing year of clinical experience. She depicted "the system" as not allowing them a personality, which in effect depersonalises them, again noted as a sign of emotional burnout (Talbot and Lumden 2000). This further emphasises organisational influences on the RN's use of humour which resonated with other participants' stories.

The students' journey towards their professional goal seems to be a bumpy road that needs negotiation due to the uncertainties of using humour. These uncertainties include the differing opinions of whether professionalism and humour can co-exist in the clinical setting. Another uncertainty is caused by the displaying of certain behaviours by RNs; demonstrating uncompassionate care through the non-use of humour or use of cynical humour, which are role modelled as professional practice.

Key findings

- Professional role models have different ideas of definitions of professionalism and humour
- Cognitive dissonance is experienced between how a professional should act and how professional roles models act, which expends emotional energy
- 'Professionalism' can be used as a mask
- Students used multiple role models to perfect what they think a 'professional' nurse should act like
- Spatiality can play a role in the use of humour
- Balancing public, professional and personal expectations within a professional context can be stressful for a pre-registration healthcare student
- Participants identified age and experience as influencing factors on role models' humour.

6.2.2 The humanity of humour

This superordinate theme stems from how the student nurses experienced the patients' uses of humour and how these influenced the nurse–patient relationship and the quality of care delivered. It comprises two subordinate themes:

- Reaching out: I am here
- Humanness: connected through uniqueness.

6.2.2.1 *Reaching out: I am here*

These findings illustrate the recognition by the students that patients, although unwell to varying degrees, are still people and, as human beings, require meaning within their life and use humour as a way to connect with the nurses who care for them.

Overall, six participants contributed to this subordinate theme. An increase in patient acuity is evident in modern day healthcare which means more acutely ill patients will be nursed on general wards. The convergent finding is that, despite the acknowledgement of the seriousness of an individual's illness/condition (which places the patient in a vulnerable position because as their care needs increase their independence and ability to control things decrease), there is recognition that the individuality of humour is ever present. The quote below shows a clear sense of Sonia's understanding of the varying degrees of patient acuity and its associated vulnerability and how humour use may be affected:

You just want to get them to a point that you recognise. That I recognise there's a person there. But of someone can banter with you, or laugh, or you can see a snippet of a person, then it makes that person real... But if someone is so sick and so poorly that they can't even open their eyes, or they can't even say anything to you, it's difficult to know who that person is (4.88–91).

Within this quote, Sonia emphasised two points: firstly, illness can act as a 'mask' (a gem which appears later in this section) and, secondly, the appreciation of how the patient, the person, is present; how humour assists the student in identifying the personality of the individual; and what humour means to the patient. The latter point was evident in the contributing participants' experiences that, no matter how ill someone was, they were still considered human.

A commonality recognised within these reported experiences was the patient using humour to convey a message of frustration or worry, communicate an underlying problem or connect with the staff. Belinda called attention to the patient as the instigator/creator of the humorous interchange in this honest account of an incident from her clinical practice in which an older man made a joke which hid his frustration at the 'younger' nurse's haste in caring for him:

So I sat down; my shift was actually finished. I sat down and fed him his pudding and we just talked about his family and everything. But if he hadn't shared that joke when I came in and got the attention, I probably would have just finished my shift and rushed (6.151–153).

Here she describes how the older man's initiated humour (also known as patient initiated humour or PIH) caught her attention and extended her presence, which

improved his care. By using humour, this man was able to connect with Belinda; he not only conveyed his frustration but also succeeded in extending her interest in him by talking about things other than his illness. Across the humorous narratives, even though the patients used PIH, it was with varying success: some RNs did not register, wilfully or not, that humour had been used.

Sonia offered another interesting perspective on PIH. She recounted a tale of a patient suffering an asthma attack who walked up the hill to be admitted to a busy ED:

Like, she knew exactly what to say, exactly how to engage the nurse and how to behave as a patient. You know, a patient patient (15.387)... I can bide my time. I'll bide my time. You'll come and talk to me; we'll have a laugh and yeah, it makes my stay here better (16.408)... so you're doing your job right by them and they're doing their job right by you, by being that patient patient (20.532–233).

Within this extract, Sonia made sense of this patient's experience by acknowledging that the patient seemed to know when to use humour to attract the nurses to her. The patient seemed to ensure her care by making herself popular to be with. The following point of consideration I would class as a gem, and it is linked with the participant's development of their professional identity (section 6.2.1.3): Sonia's repetition of "patient patient" and her description of this as the patient's job. Jobs have responsibilities and it would seem the patient's job here would be compliance as this would hasten her recovery. Compliance and being a popular patient relate to the 'good persona' image within nurse literature (McCreaddie 2008b).

The convergent finding here is the participant's recognition of PIH and the potentiality of its function to relay a hidden message, such as a patient's worries or frustration, or simply to attract the nurses' attention to ensure delivery of the required care (triggers – such as the overuse of SDH). The participants relating their experiences were more able to recognise PIH than some of the RNs who they encountered along their way.

The gem draws on Sonia's earlier quote in this theme: as she perceived it, the acuity of the patient's condition acts as a mask to their humanness (a similar conclusion could be made if other patients used humour to mask their worries or underlying

problems) which affects their ability to communicate. If the nurse wears professionalism as a mask (meaning humour use is impermissible, which makes her/him unapproachable), then they are like two masked dancers at a masquerade ball. If both are masked, they will never be able to connect as people and share the bond of humanity which allows a nurse to reach out and offer the care needed by the patient. The quality of care would be compromised as relational cues would not be received.

Key findings

- Participants acknowledged patient vulnerability
- Participants recognised patient-initiated humour and its functions
- Patients adopting a good persona and doing their 'job' by getting better are more likely to connect with the nurses
- Participants were more likely to recognise patient humour triggers within their use of PIH than some of the RNs encountered.

6.2.2.2 Humanness: connected through uniqueness

Findings specifically illustrate how unique memories from each participant's lived experiences of their use of humour in patient interactions positively influenced these relationships. The underpinning theme here is the recognition of humour and how it can play a role in the delivery of compassionate care, whether through the reciprocal use of humour or simply through sharing the humorous moment together.

All participants contributed to this theme. There was a clear understanding among the participants about relationship between the use of humour and approachability, as illustrated in Ethel's quote:

so myself, I tend to keep my smile going and I think it kinda of attracts people to me and that gives me a chance to relate better to patients (1.13–14).

From this quote, it is seen that humour acted as a social lubricant in the communication between Ethel and those around her, as humour signalled her openness to others. Using humour as a social lubricant could result in feeling confident in social company, as was the case for all participants.

Approachability and social confidence was role modelled by the participants' mentors; Belinda's quote below signifies the importance of the rapport:

So I just thought they were having a joke...I look forward to working the way... She had a good rapport [through her use of humour] with the patients. The patients knew how she knew the patients and because those patients are really sometimes very low in spirit, um, down, they've been through a lot, you as a healthcare professional, as a nurse, is to support them. Go through this journey and when you see them back, most of them... they never want to see another nurse do their chemo; they want that same nurse. I would hear them say "Is [name] around?" Or is this person around?" They would like to have that same person because of the memories of the uniqueness that they have whilst giving that care (5.116–122).

Here Belinda recounts how she is motivated by one mentor in particular, because this mentor established a strong rapport with the oncological patients she was looking after. The impression this RN, through her humour style, made with the patients is one that Belinda sought to emulate. The creation of these "memories of uniqueness" demonstrates not only the meaning that the individual nurse, through their humour use, has for the individual patients but also the RN's position as a role model for the future generations of nurses. Belinda, in the above quote, described how the nurse used humour as a communication adjunct to support patients through their difficult times.

Within both of the above quotes, arguably it was the healthcare professional's decision as to whom they made themselves available in order to share a humorous interaction. This would place the healthcare care professional in a position of power, especially within the hospital setting. It is the healthcare teams who decide the day's structure in terms of visiting hours, mealtimes, etc.; this places patients in a subservient role. If the decision to communicate (or to use humour) to signal their 'availability' rests solely with the healthcare professional this too places the patients in a passive role – a vulnerable position. Therefore, a possible conclusion from these

participants' experiences is that there is a linkage between humour, approachability and power.

Several participants did not express the connection experienced as 'patient–nurse' but rather as 'human–human', as encapsulated in Sylvie's extract as she described how people on occasion have told her how she engenders their trust in her:

"I just really trust you" because I feel like, because I think it's because I spend a bit of time with them when they go... actually chatting about something that isn't to do with medicine, it isn't to do with anything that I have to do immediately right then, it's just a, just a small, you know, just a minute; just a minute of just being another human being with that person (2.56–60).

In this quote, Sylvie highlighted the mutual trust and respect between herself and the patients as she takes the shortest of times to connect with them beyond their illness or current predicament. This human connection to the patients was core to all of the participants throughout all of the interviews and the humorous narratives. This signifies the importance of authenticity since it is the patient who is at the centre of the participants' experiences. Being connected through the reciprocation of humour was extremely valued by all participants, demonstrated in terms of their positive stance towards its usage. This was best voiced in Kellie's quote:

they have misheard me then we will have a giggle over that ... and I had a lady who I had turned around to one day and I said 'oh I will just go get the bowl' and she thought I had said 'get in the bowl', like in the M&M advert and that was it, the rest of the shift we were just saying to each other 'get in the bowl' the whole entire shift, ha, ha (7.202–203).

This reciprocation of humour between Kellie and the patient, based on a misheard word, led to a seven-hour (length of shift) connection between the two people involved. Other highlighted reciprocations of humour included listening beyond the words by recognising through humour that situations were not what they seemed (Natalie); using existing skills to engage vulnerable adults (Laura); aiding in patient–nurse cooperation (Ethel); and a patient looking forward to seeing their favourite nurse (Belinda). Each of these humour encounters demonstrated how students react to patient triggers (a key finding explored in section 6.2.2.1) or go out of their way to

do the little things, which according Ramage et al. (2014) and Sinclair et al. (2016) is when compassionate care occurs.

These participants were from all year groups and represented two fields of nursing (Adult and Child) and, through their connection with the patients, demonstrated caring for and about service users by getting in touch with the person, not the patient. These students seemed to recognise the potentiality and value of humour for connecting with, and caring for, patients.

Key findings

- Participants felt sharing humour demonstrated an openness and approachability which enhances care
- There is a linkage between approachability, humour and power within patient–student relationships
- Participants, regardless of seniority, value humour in the delivery of compassionate care as a part of their communication skill set
- Authenticity is important for the participants as they connect with people, not patients.

6.2.3 Humour influences and characteristics

This superordinate theme captures the influences on and characteristics of humour as experienced by the participants within their clinical practice areas. It comprises two subordinate themes:

- Type and functions of humour
- Influences on the use of humour

6.2.3.1 Types and functions of humour

Findings illuminate the types and functions of humour identified by nine participants across the data corpus. The types of humour experienced or used by the participants required an element of appreciation, whether it was cognitively based (for example, banter) or visually based (for example, being clumsy). The functions revolved around

these themes: a way of saving face; a work tool (often described as a key with a dual action); or a way of coping by releasing burdens associated with the job.

At this group level analysis, details of the types of humour experienced or used came from the participants' definition of humour and extractions from their humour narratives, involving both the participants and others.

For the most part, the students recounted humorous interchanges with them being the instigator of humour. Their definitions of humour often did not involve the telling of formulaic jokes (planned humour). Kellie's quote best encapsulates the types of humour used:

it wasn't like jokes or anything like that, it was just stuff you were doing (2:47).

It is the latter part of this quote that especially illustrates the types of humour mentioned, which predominantly arose spontaneously from within the moment of the situation. Banter was mentioned the most, occurring in natural conversations; word play often occurred and proved to be the funniest type of humour for the participants, for example the maxim "Lie back and think of England" (Laura). Interestingly, three participants referenced "stabbing" for venous cannulation as a form of making light of the situation, yet being stabbed would not be a pleasant experience.

Generally, the three main classifications of types of humour used were word play (linguistic/tell), spontaneous physical clumsiness (visual) and tone (paralinguistic). An audience/appreciator influence on the type of humour used was seen in the way the participants paid attention to the person's cognitive ability; whether it be Natalie in Paediatrics, or the Adult field students caring for people living with dementia, they found a common ground to communicate, best captured in Kellie's quote below:

I just gave him a jug of water and a cup and said, erm, asked him to drink it and he said no, and I had a bit of a joke about...something to do with the ocean and he didn't want to drink the ocean or something like that and I asked, I just said something like 'it's only a jug, it's not that big' and he calmed down a bit more, I think, we had a little bit more joke about something to do with water (3:83–87).

The audience's/appreciator's capacity to recognise, understand and appreciate humour was recognised by most of the participants within their narratives. In their

experiences, they expressed how they adjusted their communication skills through the type of humour to make a connection with the patient as a human being.

Gaynor was the only participant who consciously mentioned self-deprecation as a type of humour she used; however, she quickly elaborated that she would choose her audience carefully so that her competency was never in question, as demonstrated below:

yeah, laughing at your own mistake, but again I wouldn't laugh at my own mistakes in front of the patient, ha, ha, because I don't want them to be going "I don't care what she has, she hasn't got a clue... I am not letting her take my blood pressure" or whatever, but you know, some say you cock something up or just make a little mistake that's, you know (7.204–208).

Here, Gaynor had the personal expectation that she should appear to be a competent student nurse to maintain the patient's faith in her ability, which is a professional expectation. SDH was alluded to by other participants and patients within the narratives, for example a patient jokingly telling a participant of her falling outside the GP's surgery and breaking a leg, saying she could not have picked a better place for it to happen. Using SDH, making oneself the butt of the joke, could signal the patient's embarrassment, but by making herself the butt of the joke this patient offered an opportunity for shared laughter and a willingness not to take herself too seriously.

Another aspect of humour in the participants' experiences is its function. Across the narratives this could be grouped into three main categories: saving one's face, a work tool and being used for coping.

In terms of the image an individual presents, 'saving one's face' was highlighted within the narratives. In Natalie's quote below, she attempted to save an RN further embarrassment, broaching the subject of her 'nastiness':

she almost got what I was saying without having to make her feel bad about it and just sort of... "you know, all the students are scared of you" (8.186–187).

Here, Natalie demonstrated a caring and compassionate approach to both the RN and her fellow students; by using humour, she relayed a hidden message to the RN about the image/reputation she is creating for herself with the learners on the ward.

By balancing both of their needs, she potentially created a better learning environment for the students whilst seeking to help protect the RN's image.

The next function to consider is humour as a work tool. The participants described humour as having many functions in terms of relational aspects of nursing, such as to aid relationships with those around them as a means either to open communication or to probe the surroundings for information about the environment. This is illustrated in David's case by:

I use my humour as a tool to ensure that everyone around me is okay; that they can come to me and I use it as a way of opening up dialogue, or opening up a relationship between me, not only with patients, I suppose, but some of my colleagues and my fellow nurses and student nurses as well (4.101–103).

Here, David emphasised how humour, through the probing of others around him, can act as a mood indicator. Additionally, the quote demonstrates his approachability and openness to social interactions. Humour in communication was a key feature within the participants' experiences as they used humour as a means of gathering intelligence about those around them. By being familiar with people around them, the participants considered humour to be a channel to indicate the potential for a situation to turn serious. Other tool-like functions of humour included giving information about forthcoming tests and assessing a patient's cognitive state.

The final function of humour considered is coping. Coping with daily pressures was a persistent thread throughout the majority of the participants' narratives, along with how humour appeared either as a pressure-reducing or a coping mechanism. Being able to cope within an emotionally intense environment was considered by the participants to be aided by humour. Ethel, speaking for all participants in the following quote, summed their feelings up:

I think it [humour] helps me take things easy and I'm able to take one task at a time without maybe too much panicking (1:20–21).

Ethel described humour here as offering relief from a load: she has become unburdened (positive) as opposed to the experience of having no sense of direction when she is in a panic. This speaks of the intensity and duality of the emotions felt

within the clinical setting. For some, it came down to raw survival, as illustrated in Kellie's emotional quote:

I think without my sense of humour I would have given up long ago (8:244).

Using humour as a survival aide emphasises the significance of humour as a coping strategy. Both the above quotes show the intensity of emotions and the emotional demands experienced by a student nurse. There are professional expectations that these participants will adapt to the demands of twenty-first century healthcare in addition to learning their craft, which arguably place greater burden on them.

Within the context of this intensity of emotions, Belinda suggested the benefits of using humour to take the stress out of work:

maybe humour or fun can take out stress while working; can actually... As a nurse, you can actually have fun while working. This fun can actually come through humour, communication, depending on what you are doing with your patient (18:437–438).

Belinda sees humour as part of the solution, not the problem. Throughout this theme, participants considered humour to be part of the solution based on its positivity.

Key findings

- Types of humour identified included linguistic, paralinguistic and visual formats
- The humour recipient's ability to recognise, understand and appreciate humour based on their cognitive ability was recognised
- Participants were more likely to use positive forms of humour than negative
- The participants used humour as a social probe to seek out information in a way that was mutually beneficial to all
- One function of humour was 'saving face', which can protect an individual's image; alternatively, by demonstrating a willingness to laugh at oneself creates opportunities for social connections
- Participants used humour as a work tool, which can suggest these students have developed and integrated their pre-capacity for humour into a potential work or assessment tool that enables them either to raise the patient's awareness of the potential for their current situation to deteriorate or to use it as a recovery marker or mood indicator
- The use of humour as a coping strategy was seen, with particular emphasis on the emotional demands of nursing.

6.2.3.2 Influences on the use of humour

Findings demonstrate the influences on the participants' use of humour in the clinical setting. Six participants mentioned the following social identity lenses to be influences on their use of humour: diversity in culture and ethnicity, age and gender. Another influence was the context in which humour occurred.

The majority of the participants identified culture, based on a group identity (nationality or religious/belief system), as influencing the use of humour, often leading to these becoming exclusion areas, for example vegetarianism and animal rights. Overall, five participants mentioned cultural and ethnic influences on humour use, best represented in Laura's quote:

because we do live in such a diverse society, that plays a big part on people's sense of humour (6.137–138).

Here, Laura's understanding of diversity within her community is apparent as the community in which she born and lived, and where her clinical placements were, is in one of the largest ethnically diverse communities in the UK. This emphasises the socio-cultural context into which one is born and raised and how this in turn affects the development of one's sense of humour. This also highlights the diversity of modern-day British society, inclusive of regional influences and ethnicities and the associated linguistic forms used. For these participants, it was understanding the cultural triggers of humour which assisted them or their opposites in recognising or appreciating the humour proposed. In Belinda's narrative, there was an extensive focus on how she considered one member of staff's ethnicity as a barrier to her humour use due to misunderstandings.

Another social identity group recognised, by Belinda and Sylvie, was age, highlighting the cross-generational effect of humour. The extracts below give two different perspectives: one considers the age of the student, the other the age of the patient. The first, from Sylvie, follows:

not taking yourself really seriously in a clinical setting because, especially as a young person (10.314).

Of significance to Sylvie was the aim not to lose her youthful optimism within the stressful healthcare field. Further in her narrative, she expressed discomfort at her authoritative status over people in a similar age range to her mother or grandmother. The power asymmetry experienced here is one that a student will be exposed to on many levels as a part of a hierarchical institution or profession, so there is a need for people to be able to recognise such situations. The nurses' chronological age was considered in section 6.2.1.3.

Belinda's experiences caused her to reflect on the patient's age:

the older patients love the jokes and they enjoy the jokes, unlike the younger patients (1.11–12).

Belinda perceived that the age of the patient affects the appreciation of the humour. These feelings could have stemmed from an experience that she had with a younger

patient who did not agree with the type of humour Belinda used with an older patient in the same bay. The convergence between these differing perspectives is that it is the age of both the student and patient which plays a role in the use and appreciation of humour.

Being selective of with whom one shares humour, and how, was not only influenced by a person's age; both Natalie and Sylvie identified gender as influencing humour as seen in Natalie's observation:

you probably wouldn't use the same humour on a male as a female (8.210).

Natalie contemplated the increased likelihood of her using different types of humour based on the sex of her patient. Sylvie echoed this sentiment by recognising a male patient's use of humour to cope with the intimacy of an embarrassing situation (fitting of a Conveen sheath for continence reasons), which could have been used because the patient wanted to 'save face'. The influence that was potentially here is the patient's need to protect his image due to the student being a female.

An interesting point of interest was a gendered influence identified in Laura's narrative as she used sexual humour (innuendos), typically considered a masculine type of humour, with both a male and female patient.

An indirect influence on the use of humour is context: the where, when, why and with whom of using humour. One influence of the context on the use of humour is the decision to use it or not, as is being aware of exclusion zones. Recognising the context in which humour occurs was noted in the interviews because when recounting their stories the participants would smile or laugh, often under the motto "you had to be there" to find it funny (Martin 2007, p. 117). This was emphasised by Gaynor:

it's about where, it's about the context isn't it (12.359).

Contextual understanding is highlighted within this extract. This was discussed above in relation to the ability to judge the situation (section 6.2.1.1). Within the participants' narratives, no one expressed consciously choosing the 'right' time to use humour; they were more likely to be reprimanded for the timing of their humour, as it was deemed inappropriate. There seemed to be a shared understanding of

deciding about timing, for example David's continued use of humour with the dying patient or Laura's use of the rude Makaton sign to alleviate a young man's distress. Timing was implicit, as it linked to the spontaneity of the participants' use of humour, as described within the narratives. From the participants' accounts there seemed to be a strong sense of insight into certain humour triggers, such as using humour to allay one's own fears, and the direct influences mentioned above.

Key findings

- Cultural, ethnic or linguistic understanding of humour is advantageous to nursing students
- Understanding humour across the different generations is fundamental to implementing its usage and to discern the potentiality of power asymmetry in interactions between the humour creator and appreciator
- Gender may play a role in humour use. However, similarity in humour usage is noted between genders so a pre-registration nurse must therefore recognise the context and the individuality of the person with whom they are dealing
- Spontaneity and how it arises within interactions is implicit; therefore, knowing one's own humour triggers and situations where humour receptivity is hindered is imperative.

6.3 Conclusion

This chapter presented the idiographic and convergent themes emerging from the participants' experiences of humour use within the UK clinical setting. It established three superordinate themes with seven subordinate themes, under which it illustrated key findings through the use of individual participants' quotes to give voice to their experiences.

The next chapter forms the discussion around the key findings and places them within the wider theoretical and empirical context.

Chapter 7: Discussion

The purpose of this chapter is to place the study's findings within the wider theoretical and empirical context. Each superordinate theme is presented with a full discussion based upon the findings in chapter six. The gems arising from the individual themes are discussed within the relevant sections. Smith et al. (2009) highlighted the continuation of the hermeneutic circle within this section: the researcher continues to move between the part and the whole.

Key findings of the participants' (pre-registration nursing students) experiences are discussed in relation to the literature review, the wider healthcare humour literature search and the definition of humour used for this study. These are illustrated with reference to the participants' humour narratives. Each finding is considered in relation to chapters one, two and three; however, Smith et al. (2009) suggested an extra literature search may be necessary as it is possible that new angles of the phenomenon arise from the study's findings, as was the case for this study. Some findings extracted from the participants' experiences were not evident within the literature review; therefore, alternative sources were sought, either via conducting a general literature review or a Zetoc alert.

For the general literature review, a scoping exercise was conducted using keywords similar to those detailed in chapter three. The main keywords used were "humour/humor" and the point raised within the findings, for example "backstage" when discussing spatiality. An additional search technique used was manually searching reference lists from humour experts, such as McCreaddie (2008b). Additionally, I revisited article lists from HUMOR (International Journal of Humor) and the European Journal of Humour Research.

7.1 The professional journey

This section considers the first superordinate theme and draws together the main findings from the three subordinate themes: the individuality of humour, learning within the clinical setting and developing professional identity. As the subordinate themes are interlinked, certain overlaps occur; therefore, the following categories are

used to group this superordinate theme's discussion: pre-existing capacity of humour, humour awareness (including professional tension and emotional impact), the learning environment, the team, and performance and space.

It was evident within this data corpus that the participants felt strongly that humour was an integral part of their personalities (as they had a pre-existing capacity for humour, prior to entry to their nursing programme) and they were resolute not to lose this part of themselves. Additionally, they believed they had the skill to decide on the appropriateness and timings of humour use in any given situation. Therefore, the discussion first centre around the participants and their pre-existing capacity for humour.

7.1.1 Pre-existing capacity for humour

Prospective nursing students are recruited based on their individual values (things of importance in their lives) and behaviours, as well as academic qualifications. The HEE's (2014) commissioned VBR literature review suggested that students' values are what they hold to be good or desirable in life, such as a pre-existing capacity for humour, but that they may not always act in accordance with their values, due to varying external factors within a given situation. Welzel and Inglehart (2010) described how values are part of a person's identity and are therefore a good regulator of behaviours. Many of the behaviours from the HEE's (2016) updated Behaviour Framework were described within this study's participants' stories. This study's participants told of situations which demonstrated their empathy, willingness to listen, engagement of patients, treating of others as they would like to be treated and cross-team working. This was best evidenced in David's story about his use of releasive humour, a form of play, with a man suffering from a terminal illness, and his family, to ease tensions. The family supported David's use of humour by contributing more humour. Arguably, this could be linked to the participants' personal expectations of what it is to be a nurse. Badcott (2011) proposed that there should be minimal dissonance between personal values in real life and professional values in clinical practice.

It can be claimed that knowing when to use their pre-existing humour is within the participants' values sets, especially if it is believed humour is a stable personality

trait, that is, reflecting how a person thinks, feels, perceives and reacts to the world (Ruch 1996; Deckers 1998; Martin 2007; Greengross and Miller 2009).

7.1.2 Humour awareness: appropriateness and timing of humour use

The next point to consider is the decisions around the appropriateness and timing of humour use, for each participant felt able to make these. This could be termed their humour awareness, since they described how their audiences responded to their humour use/attempts either in agreement (the majority of occurrences) or not. Examples of the latter are when Belinda was the humour instigator and a nearby younger patient did not agree with her humour attempt or, alternatively, times when the participants themselves were the audience and did not agree with the humour use of another. This is illustrated in Veronica's story of the male carer commenting on the "stairway to heaven" whilst adjusting a patient's stocking: there was non-appreciation and non-agreement from Veronica as she felt it was inappropriate. These findings are supportive of Hay's (2001) audience response implicatures for humour: an audience must first recognise a humorous frame is being offered, then understand the humour being offered, then show appreciation of the humour (or not). It is at this point that the audience member can withhold full support by showing an explicit lack of appreciation through statements such as "I get it" with no laughter (this signals recognition and understanding of the humorous frame).

In Belinda's above-mentioned narrative, it is evident the younger man recognised and understood the humorous frame but did not appreciate it, as demonstrated in his lack of humour support strategies (for example, he did not laugh nor did he echo the humour). His complaint to the ward manager regarding Belinda's use of humour links to Hay's fourth implicature: agreement with the message conveyed. Hay indicated how this agreement extends to the humour initiator's attitudes, or presuppositions. The conclusion drawn from Belinda's story is the younger patient did not appreciate or agree with the humorous frame, which led him to believe her use of humour with the older man to be inappropriate.

The student participants found themselves to be in conflict with some of the RNs over their judgement of when to use humour, as shown by the fact that only three participants from this study were not reprimanded for using humour. This dissonance

between the students' judgement of when to use humour (planned or opportunistic) within a given situation and their role models' judgement (if contrary) effectively triggered a professional 'tug-of-war'. This resulted in some participants feeling they must abandon parts of themselves, namely their humour use; this created a professional and an emotional tension for the participants. The next part of the discussion deals with two issues, namely the professional tension created between the participants' and professional role models' (the RNs) humour use on the one hand and, on the other, the potential emotional impact this conflict had on the participants.

7.1.2.1 Professional tension within the student and registered nurse relationship

The goal of the student's professional journey is to achieve entry onto the NMC's nursing register and this requires an individual to begin a socialisation journey from being an outsider to a full member of an elite group of people. Such a journey requires the novice to internalise the group's values, attitudes and behaviours based on the group's knowledge and skills. This internalisation occurs in a culture of rituals and routines whilst fulfilling public expectations of nurses (Simpson 1967; Filstad 2004; Mackintosh 2005; Brown et al. 2012). Welzel and Inglehart (2010, p. 47) defined socialisation as being "the process through which humans familiarise with what is socially acceptable within their society". There is acknowledgement that there is an expectation the students' own values will change through the socialisation process (Groothuzien et al. 2018). It was apparent in this study that the participants used their allocated mentors (RNs) as their professional role models to assist them through this process. There is also an expectation that RNs embody the prescribed code of conduct (the group's set of norms) in both their personal and professional lives (Royal College of Nursing 2016). The nurse mentor is crucial to the student's development of their professional identity, as noted by Vinables (2015a). Having role models enables the student nurses to know what is expected of them, which empowers them to achieve, develop and maintain their professional identity inclusive of attitude and behaviours.

Part of the conflict seen in this study was the participants' exposure to differing viewpoints about what professionalism is and whether or not professionalism and

humour use are mutually exclusive. This is based on the participants' personal and professional expectations of humour and those of the individual mentors/role models (RNs) within the clinical setting. If the RNs themselves have differing definitions of professionalism then it would be difficult and confusing for the student to achieve a professional identity based on the group's norms. Laura's experiences are a good example of differing opinions on whether humour and professionalism are mutually exclusive as she was reprimanded for demonstrating a Makaton sign (considered to be rude) to a young man, with a condition similar to her own son.

Natalie's gem is another good example since it broaches the role models' professionalism based on their humour use and shows how Natalie used non-laughter as a challenge to the RN's legitimate power (as a representative/insider of the profession). This is a gem as it presents a different experience to those of the other participants: it is Natalie who develops the RN's professional identity through her lack of humour support (Hays 2000), not vice versa. This gem demonstrates how she experienced tension between her own and different role models' ideas of professionalism regarding the use of humour, and reveals the conflict between agency and structure (Clouder 2003; Horsburgh and Ross 2013). That is: this student's own ability to act and decide when to use humour was in direct conflict with the cultural (nursing) environment since she was not acting within the 'norm', as defined by her mentor in this situation. In Clouder's (2003) longitudinal study of 12 pre-registration occupational therapy students, exploring individual agency within professional socialisation, she concluded that although "the game" (awareness of unwritten and written rules of conduct and conformity) (p. 220) is prescribed by the profession as a means to control and regulate (which can be disempowering to the individual) it is the individual's choice to comply in order to gain entry into the membership of the profession.

For most of my study's participants, it was not the rate of entry into this exclusive membership (Rosenberg 1991) or how quickly the students adapted to the current environment or mentors' use of humour that was the issue, rather it was the cognitive dissonance felt between how a professional nurse should act and how the participants' professional role models did act, similar to Wear et al. (2006) and Parsons et al. (2001). This cognitive dissonance was not only due to the non-

inclusion of humour in patient care but also the use of cynical humour experienced. The non-inclusion of humour in care, seen by my participants, demonstrated a lack of caring behaviours, as indicated by the use of the metaphor “robot” to describe the task-orientated execution of care, devoid of humanity. This will be discussed in greater detail below under the emotional impact on the participants (section 7.1.2.2).

The participants were exposed to forms of cynical humour. The use of cynical humour within the healthcare humour literature is often associated with signs of emotional burnout (Bang and Reio 2017) and can lead to a lack of empathy (Bakker and Heuven 2006). Fontaine’s (2011) findings, from the ED, highlighted that student nurses felt their role models fell short of their expectations when they used dark humour. In Wear et al.’s (2006) study concerning medical students, the authors attributed the erosion of the students’ initial feelings of enthusiasm to challenges such as communicating with cynical staff or uncooperative patients. The authors rationalised that humour was in the incongruity of the situation; humour was being “the vehicle of expression of derision and frustration” (p. 460) that was used to manage expectations of reality versus idealisation of the clinical setting. In Rosenberg’s (1991) study, her participants noticed a change in their humour content: the more socialised into their profession they became, the more morbid their humour became. More recent studies (Newton et al. 2008; Chen et al. 2012) have supported Wear et al.’s findings that as medical students became more senior (more knowledge and clinical experience) the reported level of empathy decreased, as did their caring behaviours. Other contributing factors to the increased cynicism were poor role models, stress, and primacy of care given to physical needs (Groothuisen et al. 2018). Throughout my study, participants self-reported non-use of such humour content (cynical/dark). This implies that they were more likely to use positive humour, which they used supportively; however, this may not preclude their usage of cynical humour in the future as they become more socialised into the nursing profession or specialist areas.

Generally, there is an assumption that students will learn to be nurses ‘by osmosis’, following the traditional mode, resulting in a nurse that is obedient, is loyal to the team at all costs and has respect for authority (Melia 1987; Clouder 2003; Levett-Jones and Lathlean 2009). This could be considered their professional identity: a

construction of a 'good' student. However, students develop their own definition of a good nurse, based on influences from clinical mentors, their developing values and practice placement experiences (Lyneham and Levett-Jones 2016). This was the case for the participants in my study: they observed positive responses to role models' humour behaviours from patients and others around them in order to build their picture of an RN. Rees and Monrouxe (2010) supported this, describing how students, in their interactions with those around them (doctors and patients), develop their own professional identity. Gray and Smith (2000) highlighted how the students' insight into effective mentor qualities, inclusive of a sense of humour, assists them on their journey.

All of the participants felt professionalism and humour can co-exist within the clinical setting. The most senior students were prepared to take the risk of using humour within their patient care, regardless of the consequences. Since these are the most experienced of this study's participants, it could be concluded that the more experience students have, the more likely they are to use humour. Support for this idea, within the nursing literature and in this study's findings, varies immensely, as demonstrated by the participants' experiences and their opinions in relation to the RNs' length of qualification and their humour use.

Sumners' (1990) study of 204 professional nurses concluded that chronologically older nurses had a more positive attitude to humour use in both professional and personal settings compared with younger nurses. Conversely, Adamle et al. (2007) suggested the older, experienced, educated nurse demonstrate a more negative attitude to humour use within the professional sphere. These viewpoints were represented in David's and Laura's narratives. Thornton and White (1999), investigating the RNs' experiences of humour within an intensive care setting, determine mixed views as to whether junior nursing colleagues should be instrumental in the initiation of humour, as seen also in Coser's (1959) observations of junior doctors.

Within the wider healthcare humour literature, the question of experience and humour use elicited further conflicting views. Leber and Vanoli (2001) concluded from their study of 312 surveyed occupational therapists that the more experienced

clinicians used humour the most; therefore, the authors considered humour to be a more advanced communication skill. Conversely, McCreddie and Payne (2011) purported clinical nurse specialists (CNS), who can be regarded as senior experienced nurses, lack humour awareness. They suggest this can be due to the CNSs' perceived risk of humour use and their unwillingness to take such a risk. This is in sharp contrast to this study's senior students' viewpoint mentioned above that using humour is worth the risk.

Kret (2011) offered the argument that more-experienced nurses are colder towards patients due to compassion fatigue, which was reflected in Murphy et al.'s (2009) study on the impact of education on nursing students' caring behaviours. The latter study proposes that the educational process reduced their participant's caring behaviours, which can be linked to declining empathy. This view was similarly described in ten Hoeve et al.'s (2017) study and contradicts the aims of the VBR. The findings of this study do not support Murphy et al.'s conclusions.

7.1.2.2 Emotional impact

The impact of the conflict on the emotional tension experienced by the participants was also illustrated not only in the clash over the use of humour but also in the observed ritualistic and task-oriented care approach adopted by some of their role models.

The outcome of this conflict was seen in the way many participants described altering their humour behaviour towards their patients and others around them, dependent on whom they were working with. Tremayne (2014) detailed how humour and laughter, as natural expressions of feelings, allow a person to share a piece of his/herself with others in order to establish a genuine connection of intimacy. Being authentic, as proposed by Burnard (2002), naturally represents oneself to others, and this allows an individual to act in harmony with his/her own values, thoughts and feelings (inclusive of one's sense of humour). Barnett and Deutsch (2015, p. 107) described authenticity as "who a person is, how they perceive themselves, and how they operate on those perceptions". Arguably this is linked with feelings of agency, which Coleman (no date) defined as "the capacity to act independently and to make their own free choices". So if the participants are not using humour as they would like

to, this impacts in their freedom of choice. The participants revealed the strength of the emotional impact this restriction of humour placed on them, since it inhibited their connection with staff and/or patients, expending their emotional energy. The experienced disconnect between the participants' use of humour and the humour behaviours they were expected to replicate, could lead to emotional distancing in order for them to cope. This, in turn, may impact on their ability to deliver compassionate care, due to emotional exhaustion (the first step towards burnout).

These external forces challenge students' own viewpoints about how they use humour, which is innate (Olsson et al. 2002), denying them the emotional flexibility in situations, in which they are often powerless (Dean and Major 2008). Beck (1997) suggested humour enables nurses to deal with difficult situations, as seen in Astedt-Kurki and Isola's (2001) findings that nurses and patients used humour to cope with varying difficulties within daily routines, including those that were difficult or embarrassing. For example, in Kellie's situation, after a negative patient outcome from an emergency situation, her mentor made a humorous comment and this enabled her to regain emotional control and give attention to the needs of the other patients.

Restricting the use of humour within the clinical setting often results in nurses being portrayed as having serious demeanours (Burchiel and King 1999; Old 2012). This is traditionally seen as being a characteristic of a good nurse: the ability to develop a professional distance by hiding emotional reactions and maintaining a sense of detachment (Crawley 2004). Crawley expanded: acting professionally means engaging in emotion management. Leppanen (2008) summarised a set of emotion-focused coping strategies (aimed at managing an individual's emotional reactions to stressors), based on Menzies Lyth's (1988) work to control nurses' anxiety: conducting task-orientated care; denying the patient's individuality by calling them by the disease or bed number; detaching oneself from feelings; ritualising performances to avoid making decisions; and, finally, introducing double checking, which reduces responsibility for decisions. Some of these behaviours were described within the participants' narratives.

Stein and Reeder (2009) posited that nurses who take themselves too seriously consequentially endure higher rates of negative behaviours due to sustained stress. Knobloch Coetzee and Kloppe (2010) detailed in depth the daily emotional impact on nurses worldwide, and their well-being, who struggle with heavy workloads, inadequate staffing, an ageing workforce, limited professional development and career opportunities, working in resource-poor environments, and fulfilling a duty to deliver compassionate care. This is the participants' reality. Bakker and Heuven (2006) described how nurses are required to control the expression of their emotions and feelings as part of their job. They explained in their study of police officers and nurses that both experienced inconsistency in the displayed and felt emotions, leading to emotional exhaustion and cynicism. Sawbridge and Hewison (2013) emphasised that continual exposure to the high emotional cost of nursing can lead to burnout behaviours, such as depersonalisation and emotional exhaustion, resulting in poor care. This depersonalisation and callous approach to the patients by some of my study's participants' role models is likened, by them, to that of a "robot". Crawley (2004) argued that adopting a robotic approach is a general defence mechanism, often used by prison officers and nurses to cope with the demands of emotional work. Regardless, this can be considered suboptimal care as it focuses purely on non-humanistic task execution, which is contrary to the current drivers of caring and compassionate care (NMC 2015). Experiencing such behaviours had the potential to place further stress upon the student participants.

Knobloch Coetzee and Kloppe (2010) recognised the causes of compassion fatigue are a prolonged, intense and continuous contact with the patient, use of one's self-resources and stress. The resultant behaviours include callousness (heartlessness), unresponsiveness, indifference to patients, poor judgement and a lack of introspection (Knobloch Coetzee and Kloppe 2010). Wooten (1996a) maintained that using humour allows nurses to combat compassion fatigue that is due to the documented emotional labour associated with caring for patients. Whilst this study accepts that emotional labour, and at times exhaustion, is part of the student nurse's journey, not permitting humour use may contribute to students experiencing compassion fatigue early in their careers.

HEE (2014) maintained that people's values are shaped and learnt through childhood and become stable by adulthood but are still continually developed through social interactions with role models. This may result in a change in base values: a choice to behave in a certain way. When an individual is exposed to the process of socialisation, this may result in the internalisation of values that are contrary to professional and public expectations. Such socialisation within hierarchical structures such as nursing often places the student in a vulnerable position as Randle (2003) argued that it is the role models, the RNs, who have the power to define the student's professional identity. In healthcare, one tends to learn from preceding generations and it is this relationship which is paramount to the student's learning within the clinical setting. Potentially, therefore, the student does not become the nurse they want to be, and rather it is the context which defines the kind of nurse they do become. The student's vulnerability is twofold in that they mimic their role models within the clinical environment and it is this role model who is then required to complete the student's clinical performance assessment. Several participants' narratives detailed moments of vulnerability when they were reprimanded for using humour, or when they made a conscious decision to withhold their use of humour. It could be argued the student's psychological well-being is then jeopardised.

The reality for some of my study's participants was that they were learning their craft from RNs who were potentially experiencing emotional burnout or compassion fatigue to varying degrees, and it is these RNs who role modelled the professional values the students are expected to adopt (Badcott 2011). The senior students from this study were outspoken in their committed use of positive humour with the patients but did admit to adapting their behaviours in accordance with whom they are worked. This finding does not support Wear et al.'s (2006) conclusion that students' exposure to clinical placements and education decreases empathy. However, findings from my study suggest that adapting their humour behaviour and working with RNs who display professional values in contrast to their own costs them additional emotional energy, which adds to their stress levels. Learning to be a nurse in the twenty-first century is not easy, especially since students pay for their courses, attend clinical

placements, complete academic work and may need to work part time. This exposes them to physical and emotional burdens.

7.1.3 Humour and the learning environment

The learning environment is where students will learn their craft (Jokelainen et al. 2011), and a workplace influences a student either positively or negatively (Papp et al. 2003; Smedley and Morey 2009). One participant in Papp et al.'s (2003) study explained that the presence of humour contributes to the quality of the clinical learning environment. This quality was significant for learning and accessing learning opportunities, which enhanced their satisfaction. This resonates with the experiences of my study's participants.

Students are transient during the clinical component of their education (NMC 2010). This meant a placement change at least twice a year for the interviewed participants, in acute and community healthcare settings. The participants' experiences highlighted a humour differential between certain placements. Whilst no previous specific study was found to discuss or compare this suggestion of humour differential from the participants' experiences within the acute sector, it was the ED which was singled out as being an area where humour was prolific; it was also not a place of blame, but rather one where learning from mistakes was permissible.

Three studies regarding students' perceptions of community-based placements as clinical learning environments were found. Based on their findings, they suggested students value community placements, despite their scarcity, due to the extended learning opportunities and positive learning relationship with their mentors (Baglin and Rugg 2010; Murphy et al. 2012; Bjørk et al. 2014). Each study concluded that the student's perception of the learning environment is positive when they feel welcomed and appreciated, which relates to the experiences of the participants of my study. It could be argued that due to the informal relationship shared between the mentor and mentee (because of extended one-to-one time whilst travelling between patients' homes) the RN and student become more relaxed and this ease is therefore reflected in the care of the patient (Murphy et al. 2012). From a power perspective, Veronica, in my study, suggested that humour in this setting, when initiated by the patient, is more likely to be reciprocated by the nursing team because

they are in the patient's territory (the patient's home). Potentially, this creates a more 'fun' learning environment.

The participants' stories, especially within the ED and the community (normally with district nurse teams), share Duncan and Faisal's (1989) assumption that fun can be part of the workplace. The majority of the participants reported that they had 'fun', experienced through the supportive use of humour in these settings (for example, Kellie's experience of her mentor and her pregnant stomach on initial introductions). Several participants offered a contrasting view of acute wards, likening them to a morgue or, as one participant questioned: did the RNs know they were allowed to have fun in their workplaces?

Getting to know new people every six months is a stressful event for most students and, for the participants, it drew on their ability to introduce, settle and integrate themselves into the established placement team. Once settled into the team, the learning relationship with the mentor is established. At the time of writing, the role of the ward-based mentor for the students is one of teacher and facilitator but also, most importantly, assessor (NMC 2008b; Vinables 2015a). The common goal of this learning partnership is the student's education (which is accomplished through mutual cooperation and responsibilities, Hayden-Mills 2002) and the assertion is that the role of the mentor is pivotal in embedding the passion and compassion of nursing, which empowers the student on their professional journey. The importance of the student-mentor relationship for the student's confidence and access to learning is represented in the literature review. The two-sidedness of humour use is demonstrated in the narratives by my participants' learning relationships with mentors.

Drawing on a particular experience, Natalie's mentor's use of sarcasm (over a perceived lack of skill) can be attributed to their need to denigrate the student (this is in line with the superiority theory, in which the intent is to mock and thus demonstrate the power dynamics). Within this vertical power relationship, the mentor, as assessor, has legitimate authority over the student and their learning (Burns 2015). As the intent was to belittle (disparage), this placed the student in a vulnerable position. This is congruent with Hayden-Mills' (2002) study of female mature nursing

students' descriptions of an experience of shared humour with their clinical tutors; these students recounted how they avoided certain instructors due to viewing them as 'Despots' (p. 421). They felt that the clinical instructors held all the power because non-achievement of expectation resulted in punishment, leading them to lose confidence in their performance abilities. Losing confidence leads to a loss of self-esteem. Randle (2003) purported nursing students' self-esteem decreases over the period of training due to the hierarchical nature of nursing and the environmental considerations (organisational influences of the clinical setting), whilst Van Eckert et al. (2012, p. 903) declared "self-esteem is not typically associated with nursing".

The participants' role models' professionalism illustrated several behaviours which some authors (Vinables 2015a; Lyneham and Levett-Jones 2016) described as poor mentoring as they elicited the feeling of 'Big Brother watching you'. Several participants, in my study, alluded to feeling watched, which gave them the sense of having to be constantly on their guard; additionally, they felt this affected the role model's approachability. The participants' experiences are suggestive of Maben et al.'s (2006) notion of professional sabotage (poor role models and patient non-engagement). Several participants detailed further situations of mentor non-approachability and how it limited access to learning opportunities, often self-imposed by the participants. If the power asymmetry experienced can induce feelings of fear or being infantilised, as noted in the participants' narratives, then Meisner's (1986) accusations are upheld: nurse educators cannibalise the 'young', thus ensuring their failure to thrive through the authoritarian approaches adopted and a lack of support. Anderson and Morgan (2017) supported the idea of nurses eating their young as their study details intergenerational hostilities being prevalent within the nursing population of the USA. McCarthy et al.'s (2018) literature review described how such difficult relationships within the clinical environment are one of the key causes of stress for nursing students.

Conversely, the positivity of the mentor–student relationship is represented in several accounts in my study. This is in keeping with Nahas' (1998) and Hayden-Mills' (2002) findings: by decreasing the social distance between mentor and student, through the use of humour, the opportunities to achieve expand through a reciprocal relationship of trust and connectedness. Rowbotham and Owen's (2015)

study suggested feedback by the clinical instructors produced higher student self-efficacy since they proposed ways of improvement through positive reinforcement and correction without belittlement. Lei et al. (2010) acknowledged the power of humour as a teaching tool to promote all facets of student learning.

Nursing humour literature (Robinson 1977; Parkin 1989; Hayden-Mills 2002) has purported that the use of humour within the clinical setting produces a caring environment, conducive to learning, built through good rapport due to open and flexible communication between student and mentor (Watson and Emerson 1988). These are the environments in which the students are socialised into the nursing profession, and it is through shared practice with their mentors and the role modelling of respectful, professional caring behaviours that the students understand what it is to be a nurse (Hayden-Mills 2002). Reciprocal relationships in such environments allowed criticisms or clinical errors to be discussed without crushing the student's self-image. This echoes this study's participants' sentiments towards the role models with whom they shared positive humour occurrences.

7.1.4 Humour and the team

Several previous studies have emphasised how the student nurses, or the newly graduated nurses, need to belong (seen in their trying to fit in with the locally accepted customs, rituals and routines of nursing) and how this overshadows the importance of the learning experience (Melia 1987; Levett-Jones et al. 2007; Sedgewick and Yonge 2008; Levett-Jones and Lathlean 2009; Malouf and West 2011). The need to belong arises from a human need to be accepted within a social group, for not being accepted leads to consequences for the individual (Baumeister and Leary 1995; Sedgewick and Yonge 2008). This need can act as a motivating force for the student nurse to integrate at all costs (Levett-Jones et al. 2007). In Sedgewick and Yonge's study (2008), one preceptor detailed how the lack of certain characteristics, such as a sense of humour, could potentially lead to the non-integration of an individual nurse into the team.

Building team cohesion is imperative in a discipline such as nursing since it is the team that delivers the care through the actions of individuals, and using banter as a form of humour enables the team members to support each other and work

cohesively (Beck 1997; Thornton and White 1999). Within the nursing teams, my study's participants' experiences of teamwork and the use of humour depict a varied landscape. Within such learning environments, Wooten (1997) suggested that humour is an essential tool for all professionals wishing to remain compassionate; caring also plays a role within the wider team, as explained by Smyth (2011). Students aim to be part of the team, because feeling they belong enriches their learning and they can become more confident to practise clinical skills (Vinables 2015b).

The ability to integrate within the team and feel like an insider was expressed by my study's participants as being dependent on connecting with those with whom they worked, either by accepting that others have a different sense of humour within the team or by fostering the feeling of 'we are all in it together' (Malouf and West 2011). Ethel suggested that a consequence of not using humour is that teamwork does not exist and regresses to task completion, affecting both student experience and patient care.

Beck's (1997) study highlighted how humour creates a sense of cohesiveness for the nursing team and is an effective communication tool amongst colleagues. Being able to use humour allowed the interacting parties to break down barriers, especially as shared humour content exists (described by Robinson, 1977, as 'in' jokes). These 'in' jokes denote a shared togetherness gained through mutual understanding of the same conflicts experienced by all; this facilitates group solidarity (Robinson 1977). Of certain significance to my study's participants, is the sense of belonging: the narratives emphasised how a positive relationship with the mentor, enhanced through the use of humour, leads to one being an 'insider', meaning learning can begin. Vinables (2015b) suggested that students will emulate their role models, either intentionally or unintentionally; therefore, mentors in already established teams act as stepping stones for the students to integrate into the team since belonging means team success (Sedgewick and Yonge 2008).

Integrating into a team can be difficult: one participant in Thomson's (2010) study was noted to be an outsider until she began to partake in the banter, marking what Thomson termed "communal ownership" of humour, which can be used as a sign of

group membership (p. 4). Within my study, Laura described how she openly challenged attitudes to humour use by using humour with the patients. Holmes and Stubbe (2015) explained that humour is typically used to build and maintain good working relationships, which solidifies insider status within the group, and yet in Laura's example it seems that she wished to remain an outsider, identified as a rebellious student, within her current placement. This is in keeping Holmes and Marra (2002b) assertion that using humour within the workplace can be used to air grievances in a socially acceptable manner.

Each discipline within healthcare has a role in delivering good quality and safe patient care, which is an outcome of collaborative practice (Balzer 1993); therefore, teamwork is essential (Health Foundation 2015). Traditionally, medical staff assumed the role of leader within these teams due to their clinical expertise, especially within hospital settings (Dean and Gregory 2004). Manjlovich (2007) contended nurses are powerless, especially within hospital hierarchies, yet Dean and Gregory (2004) noted a physician's attempts to flatten the power hierarchy by using humour to put others at ease. This mirrors Coser's (1959) findings from formal staff meetings between senior and junior psychiatrists, where humour was used to flatten and release the hierarchical formality in a very structured environment. In other words, it was the senior staff who initiated the most witticisms; this was always higher- to lower-ranking group members not vice versa (Coser 1959). This is replicated in Wear et al.'s (2006) study.

Within my study, two participants spoke directly of experiences with medical staff, one with a consultant and the other with a medical student. Both examples were attempts at building a common group identity by showing solidarity through the use of humour. The participant's experience with the consultant was that she laughed at the consultant's joke as he attempted to put others at ease during the ward round, and it was noted that the joke was made at the expense of the patient (the consultant joked the patient "talked for England", based on the numerous questions posed). Additionally, she mentioned that she would never consider initiating a humorous occurrence in the presence of those more senior to herself. The other participant's experience with the medical student was one of equals since she assisted him/her to catheterise a patient for the first time. However, it could even be argued that as a

third year nursing student she had seniority over the medical student, as her expertise in catheterising was greater, meaning that a similar scenario to that with the consultant was played out.

7.1.5 Humour, performance and space

Arising from my findings were the ideas of a performance and masks. The performance for various audiences takes place in the public areas; this connects to spatiality playing a role in different humour uses. For example, some participants described how nurses would retire to areas away from the patients' earshot/sight (nursing personnel areas: 'back region') and then humorous occurrences would take place (humour type used was undefined) because the role models felt that patients should not see nurses laughing. It is in these back regions, the public (audience-facing impression) expectations of a nurse's performance are contradicted by, for example, the use of gallows humour. This means nurses acting differently with familiar people, so they become relaxed away from the public area. These areas, as described by the participants, only exist within hospital-like settings. This finding concurs with Parsons et al.'s (2001) findings about cynical humour: it is best used in the areas away from patients' hearing.

Cain (2012) suggested behaviours associated with compassionate care occur in public areas, meaning images concurrent with the professional image are maintained, whereas in the nurse-only region, behaviours associated with detachment and dark humour persist. Watson (2011) specifically mentioned gallows humour use in the backstage areas of healthcare settings. She rationalised those who critique the use of such humour out of an empathic patient-perspective ignore, or demonstrate a non-empathetic stance towards, the healthcare team who use it as a coping mechanism (a well-documented concept within healthcare humour literature, Martin 2007). However, Watson argued that such humour use should be done only backstage and for the right reasons (intentions).

Backstage areas are considered regions where people can relax and be familiar in a way that may not be considered suitable elsewhere (Tanner and Timmons 2000), yet having backstage areas establishes and affirms intimacy amongst the group (Watson 2011). Morgan and Krone (2001) considered co-workers to be an audience

of equals and it is here the professional mask is dropped (for example, using humour as a form of protection), a point emphasised in Sonia's narrative (discussed below). Crawley (2004) extended this to define these areas within organisations as being "emotion zones", and said that such areas are places where people can express behaviours which "blow off steam" (p. 420). She defined the acceptability of such behaviours (inclusive of humour) in terms of the "feelings rules" of the organisation (the types of emotions that can be openly expressed): "feelings rules are the subtle product of working arrangements and the social history of each workplace: unspoken and largely invisible, they regulate myriad impression-management behaviours as well as the open expression of feelings" (p. 417).

Within the backstage area, audiences vary. However, for humour to be shared, common experiences must exist (Charman 2013), and in times when emotions are communicated through humour then dissonances (cognitive and emotional) evaporate as the emotions become collective (Crawley 2004). Charman (2013) considered humour to be a symbol of the organisation's culture and it is within these backstage areas students become socialised through an informal, hidden process (through observation and participation) to the organisational norms (Morgan and Krone 2001; Ellingson 2003). Belinda, from my study, described how it is here, through shared humour behind these closed doors, that she learnt how to "read" her colleagues, which assisted her in working with them more collaboratively in the patient-facing areas. Humour acted as the "social glue" to embed Belinda into that team (Charman 2013, p. 157).

Extending upon the participants' experiences of professionalism being used as a mask (either to protect oneself or adopting particular ways of behaving), it is here Sonia's gem, in my study, arose: she discussed how she sees illness as a mask which obstructs her from seeing the patient as a person, which she feels does not allow her to engage with a patient on a humorous level. However, problems may also occur if the patient uses humour as a way to mask their underlying fears and anxieties. Consequently, if both are masked, they will never be able to connect as people and share the bond of humanity that allows a nurse to reach out and offer the care needed by the patient. This then becomes problematic as the patient's needs potentially remain unmet.

In terms of the question, 'can professionalism and humour co-exist in clinical practice?', there is ambiguity. Based on NMC (2012) statistics, between 2011 and 2012, 66 per cent of RNs referred for 'Fitness to Practise' hearings were aged 40–59 years, with the majority based on misconduct allegations of which 44 allegations included references to humour (NMC 2016). Yet Haydon and van der Riet (2014) argued that using humour minimises the potential feelings of dehumanisation for the patients, which is supported in McCreddie and Payne (2011) when one of their participants determined the nurse's competency during a humorous interaction, easing the patient's concerns. In addition, Rosenberg (1989) suggested that being able to laugh at oneself embodies an outward-facing image which enhances the reputation of nursing, as one is considered to be human.

Interwoven throughout the preceding sections is the showcasing of the development of the participants' professional identities and how the varying functions of humour were utilised. From the participant/student perspective, this study found this group overwhelmingly used humour to solidify relationships with those around them – RNs and patients. This demonstrates the lubricating effect humour had on the participant's social interactions as they solidified their in-group statuses and sought integration into the new teams with every placement change. However, when the RNs, in the participants' stories, used humour it was either to solidify relationships or to control the behaviour of the participants/students according to their individualistic definitions of professionalism despite NMC guidance and policy drivers (Hay 2001; Ferguson and Ford 2008; Janes and Olson 2015).

In forming their own professional identity, it seems the participants needed to constantly navigate transitioning from outsider to insider roles. Identity struggles are not uncommon; Benwell and McCreddie (2017) illustrated how even for NHS telephone complainants establishing a good persona was important. For my study's participants, establishing a good persona according to the mentor's expectations was necessary because they were assessing them. The idea of students establishing a good persona, similar to the patient's, is one which warrants further investigation.

To conclude this superordinate theme, based on my study's findings, it is suggested here that student nurses need to negotiate their humour identity throughout the professional socialisation process based on their pre-existing humour capacity and the influences they meet along the way. If they meet influences contradictory to their own valued use of humour, this causes an emotional and professional tension for the student as they could be potentially robbed of one of their coping mechanisms. Additionally, there may be a need to adapt their humour behaviour to those around them or remove themselves from learning opportunities.

7.2 The humanity of humour

This section considers the second superordinate theme, the humanity of humour, and draws together the main findings from the two subordinate themes: 'reaching out: I am here' and 'humanness: connected through uniqueness'. It focuses on the patient–student relationship.

7.2.1 Reaching out: I am here

Humour as a social phenomenon is known to set out boundaries between social groups or to create solidarity within them (Søndergaard 2012). Many of my study's participants (31 out of 45 stories told) recounted stories of positive humour use which acted as a lubricant within the patient–nurse interactions. This relates to Martineau's (1972) formulation of humour acting as an aid or barrier to the mechanisms of social interaction. Participants used humour more frequently to overcome perceived barriers than as a tool to maintain the patient–student nurse divide, as seen within the discussions of RNs in section 7.1. For the participants, sharing humour demonstrated their human side, resulting in an individualised approach for the patients. And, after all, patients remember the little things (Erdman 1991; Old 2012), such as Kellie's "get into the bowl" interaction.

In this study's literature review (chapter 3), a theme not mentioned was PIH: a patient using humour to connect with a nurse. Within my study, each participant recounted stories of observing RNs who did not recognise incidences of PIH. PIH accounts for over 70 per cent of both nurse and physician interactions with patients (Adamle and Ludwick 2005). Adamle et al. (2008) argued that PIH is the patient's

attempt in a non-threatening manner to express their individual needs to the nurse, thus sharing their perspectives on situations in times of stress. Adamle and Ludwick's (2005) and Adamle and Turkosi's (2006) studies of PIH explored how it occurs spontaneously, without cues or prompting, in various situations. This could be seen specifically in Belinda's account of the older man using humour to convey his frustrations. This use of PIH demonstrates the intent to convey a message without embarrassing others (nursing staff).

The main reasons patients use humour within healthcare encounters are to: cope with an unpredictable situation; obtain relief from the current situation; build rapport; gain perspective of the current situation either through denial or distancing themselves; convey covert messages; reinforce control of the situation; or express anger or frustration at treatment, illness, or staff competence (Emerson 1960; Francis et al. 1999; Astedt-Kurki et al. 2001; Adamle and Turkosi 2006; Moore 2008; Branney et al. 2014).

Shattell (2005) explained how her participants (patients) actively engaged in strategies to lure the nurses into forming a friendly relationship through conversation and humour, by taking an interest in their pastimes and making them smile. This is particularly relevant in Sonia's account (in my study) of the asthmatic patient who used humour as a means to draw Sonia into her cubicle to receive care. Stockwell (1972) introduced the concept of patient popularity and how special dispensation was given to popular patients as the nurses found them easy to communicate with – they were fun and had a good sense of humour. Price (2013) posited, from the patient perspective, that once someone is labelled as being difficult they become more disadvantaged since it is the nurses who construct the daily reality on the wards. More recently, this trend is seen in Campbell et al.'s (2015) Zimbabwean mixed methods study on ART (antiretroviral treatment) adherence: patients who were felt by the healthcare providers not to be acting within the characteristics of the 'good patient persona' (obedient, patient, polite, a listener, willing to adhere to the treatment regime, physically clean, honest and grateful) were disadvantaged (for example, they may have been made to wait longer at their clinic appointment). They concluded this could negatively affect patient outcomes and lead to a detrimental breakdown in the patient–HCP (healthcare professional) relationship.

McCreaddie and Wiggins (2009) highlighted two aspects of the good patient persona as being compliance and “sycophancy” (over gratitude). Sonia saw compliance in her description of the patient’s job responsibilities since it seemed that she felt it was their job to get better. The description of the patient’s job and its associated expectations is reminiscent of Parsons’ (1951) “sick role”, namely to get better and show willingness to recover by cooperating the healthcare staff (Varul 2010; Price 2013). Price (2013) proposed the reciprocity of the patients fulfilling their expected role potentially defines their level of care. This is evident in Shattell’s (2005) argument that patients’ performances as good personae resulted in the likelihood of the nurses being more responsive in times of greater vulnerability, for example in life or death situations.

The suggestion arising is that if a patient is compliant and humorous, then the nurses are more likely to tend to them in times of need – a suggestion supported in Kadhill’s (2009) study, and resonating with Michaelsen’s (2012) study, in which the nurse participants described using an avoidance strategy with difficult patients, by either being non-present in the moment (which resulted in missed care opportunities, potentially to the patient’s detriment) or asking for the patient to be removed from their workload. So potentially the nurses who are oblivious to PIH are actively engaged in using avoidance strategies. This is consistent with the fact that several authors have noted the majority of laughter in PIH is not reciprocated (Haakana 2002; Adamle and Ludwick 2005; Adamle et al. 2008; McCreaddie and Wiggins 2009), thus emphasising social distance (Squier 1995).

The mentioning of shared laughter within my study’s accounts fulfils Martin’s (2007) definition of it being a vocal expression of humour. The shared laughter marked times of intimacy between the participant and the patients. Using laughter in an affiliative way evokes the saying ‘laughing with someone’, as opposed to ‘laughing at someone’ in a disaffiliative way. Coser (1959) ascribed shared laughter to a signal of equal status within the relationship (Dean and Major 2008). This links back to the studies of Wear et al. (2006) and Parsons et al. (2001) in which the patients are not considered equals and often the motive for using emotional distancing strategies (by medical staff) is to cope with the situations at hand. Within this study’s participants’ narratives, no participant described their humour as being used to distance or set

boundaries in the patient–student relationship, rather they used it in solidarity with the patients in an attempt to draw them closer.

Shattell (2005) maintained that by using humour, her participants (patients) hoped to fit into the ‘easy patient’ category, synonymous with the ‘good patient’, since this ensured survival. This relates to the perception that the hospital is an insecure environment, echoed in Sonia’s “they feel safe because they’re in their own home” (8.202-204), which she extended to include the patient’s willingness to share banter. My study’s participants seemed to recognise patients’ vulnerability on a physical and emotional level since they described times when it was the RNs who decided when or not to use humour; by determining their approachability, the RNs nursing staff potentially placed patients in a vulnerable position because it stifled communication possibilities and could have made the patients hesitate to open up to the nursing staff (as Veronica alluded to in one of her narratives). This demonstrates a disparity in the relational power and contradicts a person-centred-care approach: the holistic assessment of the individual (Ferguson and Campinha-Bacote 1989) and policies such as *No decision without me* (DH 2012a). These had the goal to increasingly incorporate patients into their care decisions and create an expert patient, thus beginning to flatten the hierarchy between patient and the professional team. My study’s participants, in their accounts, demonstrated how the frequency of their humour usage helped to challenge this hierarchy.

A prevalent patient strategy, as Du Pre and Beck (1997) concluded, is the patients’ over-exaggerated self-disparagement (SDH), which enables them to seek forgiveness and reassurance for non-compliance with treatment in the most non-confrontational way possible. Reviews by Dean and Gregory (2004) and McCreddie and Wiggins (2008) suggested the explicit use of SDH by patients is a means to connect with the healthcare staff or communicate their deeper worries. In my study, there were only two participants who specifically mentioned patients’ use of SDH, and the two functions seen were not taking oneself seriously and a means of coping. McCreddie and Payne (2011) noted that when the patient’s use of self-disparagement goes unnoticed, it becomes potentially problematic since the nurses may miss its underlying meaning which results in either a missed opportunity for the patient to unburden themselves of their worries or complaints, or a delay in

intervention. The problematics of using SDH were a key feature of McCreaddie's thesis (2008b).

Across the participant's humour stories, the majority involved incongruous humour, defined by McCreaddie (2008b, p. 119) as having "a mismatch of content with context that is incongruous" (see Appendix four). One example of this is Sonia's story of a woman saying she has a "pea in the bum". McCreaddie (2008b) posited that incongruous humour is a non-problematic type of humour since it is easily recognisable (to identify and understand); therefore, it is most likely to be reciprocated and potentially involves less risk, as illustrated by the CNSs in McCreaddie's study. She rationalises that the increased reciprocation is because incongruities are more explicit, based on commonalities and limited to things both patients and nurses recognise, such as hospital procedures or processes.

McCreaddie and Payne (2011) posited that there is a gulf between the amounts of humorous interchange desired by the patients and what they experience with the CNSs. They concluded that the patients will adopt a good persona, to varying degrees, to ingratiate themselves to the CNSs to achieve a meaningful relationship. This assumes that the patient's humour remains the same in good or ill health; however, McCreaddie and Payne establish that the patient's appreciation of humour may differ when ill, as evidenced in the patient's immediate responses. In my study, it was Sonia who focused on patient acuity acting as a mask to the individuality of the patient's humour appreciation. Therefore, recognising the patient's ability to appreciate humour is imperative since this could affect further communication between the patient and student. Another contributing factor noted by the participants was the patient's cognitive ability, a lowering of which may hinder appreciation of any humour use.

To conclude, the participants of my study felt humour is part of their communication skill set, evident in their use of it as a social lubricant with the purpose to strengthen their relationships with patients through creating feelings of solidarity and reducing social distance. The participants considered themselves to good communicators, as they demonstrated openness and empathy and recognised patient vulnerability. Even though the participants adopted a person-centred approach and recognised

when PIH was used, only one acknowledged how a patient used humour to present a 'good' patient persona in order to influence the care received. Not many participants were able to distinguish or recognise patients' use of SDH, which is problematic.

7.2.2 Humanness: connected through uniqueness

Patients are no longer considered passive recipients of healthcare, rather they have greater expectations of professional health services and knowledge of both how to access services and the types of services available for their own conditions (Astedt-Kurki and Haggman-Laitila 1992). Therefore, this increases the patient's expectation in all aspects of the clinician's practice. Two overarching themes, within the literature, concerning patients' expectations are the need for open and honest communication, offered in a genuine, warm and empathetic manner, and being seen as an individual (McCabe 2004; Fleischer et al. 2009). Furthermore, many regard humour as a communication tool that can positively impact on the patient–nurse relationship (Dean and Major 2008; Moore 2008) and be used to convey genuineness, whether through verbal and non-verbal actions (Mallett 1993). My study's participants supported the previous sentence as they felt shared humour signalled their openness and approachability. They used humour in an affiliative, playful manner to emphasise the shared experience, which, in turn, enhanced care (McCreddie 2008b), for example when Veronica laughed at a patient's attempt to fashion a drip stand out of coat hangers. She engaged with the patient on a human–human basis, an authentic presentation of self was important to the participants.

Adamle and Ludwick (2005) explained that through humour, a natural expression of emotion, our inner self is revealed; as such, it offers intimacy in relationships by giving a piece of ourselves, as detailed in Branney et al. (2014). This shows humour can influence daily communications, which for student nurses are with patients and other staff members. In their accounts, these students demonstrated, through their willingness to listen, an ability to be empathetic, showing genuine concern and valuing the patient as a fellow human; consequently, many of the participants considered humour to be part of their nursing communication repertoire. Communication is a core skill for students and RNs alike and needed to deliver compassionate care. These participants valued humour and felt it had a place in the delivery of compassionate care.

Hampes (2001) highlighted the link between the use of affiliative humour and empathetic concern, a link which is evident in a person's warm feelings, compassion and concern for those having a negative experience. Both having a warm regard and demonstrating concern for others can be argued to be part of being human; therefore, nurses do not have the monopoly on caring (Griffiths 2008). Firth-Cozens and Cornwell (2009) concluded that compassionate care includes empathy, which is an ability to understand and acknowledge another's feelings, based on individual differences, whilst recognising their vulnerability and being willing to offer assistance, as also acknowledged by Griffiths (2008), Ramage et al. (2014) and Sinclair et al. (2016).

Discussions concerning the teaching of compassion are noted in Pence (1983), Wear and Zarconi (2007) and Sinclair et al. (2016). There is agreement amongst these authors that innate abilities at recruitment act as a baseline for compassion development. Rolfe (2014) different humour uses. For example, some participants, however, maintained that compassion cannot be taught because it is just part of just being good. Firth-Cozens and Cornwell (2009) argued that humour forms part of compassionate care, provided it be at the right time and place – which all participants, in my study, wholeheartedly agreed with and felt the judgement of which lay within their ability (see section 7.1.1). Sinclair et al. (2016), in their scoping review of compassion, detailed studies which ranked compassion as the most important feature of healthcare from the patient perspective. Rupp Wysong and Driver's (2009) study found their participants measured a nurse's skill by their interpersonal ability, which included a sense of humour. So the suggestion, from my study and that of previous studies, is that there is a patient need for nurses to incorporate humour into their care.

For my study's participants, their focus concentrated predominantly on how their use of humour created feelings of solidarity and connection with their patients on a human level. By doing so they meet the governmental agenda of providing and improving compassion within healthcare, which halts a decade of falling reputation for the nursing profession through the consecutive care scandals, such as the Mid-Staffordshire public inquiry, which highlighted nurses' failure to care (Griffiths 2008).

7.3 Humour influences and characteristics

This section focuses on the two subordinate themes of the third superordinate theme: the types and functions of humour and the influences on its usage.

7.3.1 Types and functions of humour

The following deals with the types and function of humour identified within the participants' narratives. Throughout the majority of their humorous narratives, the participants told of encounters predominantly with patients. The types of humour arising from these spontaneously occurring interactions were not formulaic in nature, but uses of unplanned humour (Martin 2007). This was congruent with participants' definitions of humour.

7.3.1.1 Types of humour

The types of humour used throughout the narratives typified those listed within chapter 2 (Figure 2.4). Stigel (2008) listed humour types along a continuum of physical and verbal humour, further divided into four forms: visual (observable), dramatise, perform and tell. Although these groupings were used originally within the advertising industry, and may be more associated with planned humour, they are applicable to this study as a means of categorising humour forms, since the context was a determining factor for these participants' intentional/unintentional use of humour. It was difficult to establish other forms of spontaneous humour, such as those reported by Hay (2000), because of my reliance on the participant's ability to relay their humorous story, in the fullest detail, based on their memories. Across the narratives, the majority of the humour types fell into the 'tell' category (Stigel 2008), for example word play or misheard words. When considering the types of humour listed in Hay's taxonomy, fantasy humour, for example, would fit in with Stigel's 'tell' category. Therefore, I decided to use Stigel's categories it simplified humour typology to use as a base for the humour awareness compass (section 7.6).

The most commonly mentioned type of humour to be used was banter, which was best defined by Norrick (1993, p. 29): "a rapid exchange of humorous lines orientated around a common theme, though aimed at primarily at mutual entertainment rather than topical talk". According to Dynel (2009), banter can be

supportive and collaborative, as was the case within my study participants' experiences. A good example of this is Kellie's story of a misheard word and how she and the patient laughed over this for the whole shift. The participants told of adjusting their banter to meet the patient's cognitive level, demonstrating their supportive use of humour.

The next type of humour to consider is self-deprecating humour (SDH). This was evident in some of the accounts, especially those involving patients. Through her use of SDH, Gaynor highlighted her willingness to laugh at her own mistakes before someone else pointed them out (Gkorezis and Bellou 2016). A point of consideration was the audience with whom one self-deprecates; Gaynor was only willing to use SDH in front of the healthcare team. From the audience's perspective, how they reacted to the use of SDH was a balance between supporting the humour and signalling they understood it but disagreed with the message it conveyed (Hay 2001). By restricting with whom she self-deprecates, Gaynor appears to be protecting her image of competence in front of the patients. Both public and professional expectations are demonstrated here since she is trying to protect her professional 'face' as a knowledgeable practitioner.

Martin (2007) suggested that an expression which permits one to save face is, 'I was only joking', thus making it possible to withdraw the 'joke' and ensure both parties are protected from an awkward or embarrassing situation. Nurses care for patients at the most vulnerable times of their lives; it can be argued, therefore, that nurses are often in the position to use face-saving humour. Kane et al. (1977) described face-saving in terms of maintaining identity whilst a potentially confrontational or embarrassing situation unfolds. Goffman (1961) described the maintenance of 'face' as a mask each individual dons in order to prevent embarrassment, achieved by following social norms which require self-respect and consideration for others, maintaining the ritual order of social life (Branaman 1997, p. lxvii). This means both parties retain 'face' and dignity, consequently making them monitor their responses. Saving 'face' is therefore about maintaining one's image for others (Goffman 1955, 1961; Manning 2007).

According to Branaman (1997), 'face' is allocated to individuals by society; respect is awarded due to social status and one is expected to act accordingly. Natalie's attempt, through humour, to convey to an RN that the students find her unapproachable, drawing her attention to the impression she makes on Natalie's peers, was an example of saving her 'face'. Therefore, it can be rationalised that it was Natalie who acted within the public expectation of being kind as she attempted to prevent future conflict for the RN. Two other types of humour mentioned in my study were 'dark' and cynical. These again would be classed under Stigel's (2008) 'tell' category as they originate mainly in linguistic form.

Beginning with 'dark' humour, Buxman (2008) offered alternative names, such as "medical" or "black", and provides possible descriptions: obscene, grim or macabre. This type of professional humour, also known as gallows humour, is distinguishable from 'sick' humour since it involves laughing at one's own circumstances rather than aggressively making fun of others (Moran and Hughes 2006; Buxman 2008). Gallows humour is founded on witty banter, based on the absurdity of the situation, and exchanged when placed in a no-win situation (Kuhlmann 1988). This can be linked to the body of work on the relief/release theory of humour; Keith-Spiegel (1972) explained that the function of this humour type is to offer relief from strain or constraint, or to release excess tension. Christoff and Dauphin (2017) clarified Freud's jokes as being the conversion of unacceptable impulses or emotions, such as cynicism or aggression, into pleasurable ones, such as laughter. They continued that adopting a humorous approach to life assists with adaption to suffering. Robinson (1991, 1995) highlighted specific areas, such as emergency departments (ED), critical care units and theatres, where anxieties are highest (the risk of patient death is greater) and, therefore, the situation is tense. The use of humour can reduce these anxieties, as detailed by Dean and Major (2008). Fontaine's (2011) participants, who were RNs, felt gallows humour is a prerequisite for nurses in the ED. The participants in my study did not specify the use of gallows humour in this clinical area, but overall felt ED was a good place to learn from mistakes made. Smyth (2011) argued that gallows humour is not necessarily as synonymous with derogatory humour as cynical humour is.

Cynical humour was a prominent theme in the literature described in chapter three (section 3.3.3). Cynicism, and subsequently, cynical humour, has been associated with emotional burnout resulting from chronic stress (Smith et al. 2018). In my study, Veronica did not describe the situations in which cynical humour was used, but did state that many RNs used it. She did not elaborate on how it made her feel, how it affected her or how her impression of these nurses altered. In Wear et al. (2006), the senior medical students understood the motivations behind the use of cynical humour, such as it being used to cope with stressful situations. Similarly, within my study, the participants had an understanding about why certain types of behaviour (non-use of humour) existed, based on organisational demands such as increased workload.

In relation to this study's definition of humour, there is an overwhelming positivity towards the use of humour since most of the participants described experiences in which the intention was to produce positive emotions or thoughts for their audience, or vice versa, when the patient/mentor was the instigator of humour. This promotes the idea of humour acting as a social lubricant. However, in consideration of the duality of humour, there were incidences within the participants' accounts which led to discomfort, either on their part or the part of the patients/mentors. Consequently, regardless of the humour type used, it is the intent behind humour which makes it either positive or negative. This leads on to the functions for which humour is used.

7.3.1.2 Functions of humour

Humour research in nursing has indicated the ability of humour to be used as a nursing intervention tool or for therapeutic use (Dunn 1993; Hunt 1993; Minden 2002; Shields 2014). My study expands this understanding since the findings indicate student healthcare practitioners use humour as a work tool. Robinson (1977) maintained that humour can be used in the healthcare environment in a playful manner, allowing hidden meanings to be transmitted in a non-threatening manner to or from patients. Based on Robinson's assertion, it could be suggested that although the nursing students are at different points within their education, they have developed and integrated their pre-capacity for humour into a potential work/assessment tool. This tool can be used either to raise the patient's awareness of the potential for their current situation to deteriorate, or to assess a patient's recovery or

to act as a mood indicator. Therefore, a move away from seeing humour as a therapeutic tool to seeing it as an assessment tool is possible. Shields (2014) formulated a holistic history-taking of the client's humour use to be undertaken as part of the nursing process; however, an argument against a rigid assessment checklist was posited by Dunn (1993). She expressed the idea that rigidity in patient exchanges can occur when humour is consciously used, which could prevent humour from being a key to open up communication between caregiver and patient. A compromise between the two suggestions would be to capture humour histories from those patients with impaired communication modes; for example, aphasic patients, post stroke or patients with cognitive impairments.

Using humour to enhance communication has been highlighted within the wider humour literature as one of the functions of humour within social interactions. My study's finding of participants using humour as a work tool suggests that it acts as a lubricant between the social actors to foster information gathering and social integration (Ferguson and Ford 2008). This social integration occurs not only between the student and the patient but also between the student and the wider healthcare team which, arguably, provides the student a means to solidify their in-group status.

Humour as either a coping or defence mechanism is not a new concept within the humour literature and has been linked with the relief theories of humour (Martin 2007). There were no examples of humour being used defensively by any of the participants in my study; however, the use of humour as a coping strategy was prolific throughout several participants' accounts.

Nurses provide care in various settings and over a twenty-four-hour timeframe. These clinical environments require them to work quickly, efficiently, resourcefully, competently, compassionately, caringly, initiatively, and with a focused commitment to individualised, holistic care whilst remaining emotionally flexible (Dean and Major 2008). Being able to switch emotions from sadness at the poor outcome of a cardiac arrest to welcoming a new patient onto the unit in the blink of an eye is required of nurses, regardless of setting. This was seen particularly in Kellie's example of a cardiac arrest with a poor outcome and the way in which her mentor used humour to

assist her with the arising emotions. This is congruent with Billig's (2005) example of cognitive and emotional reframing, and similar to the paramedics in Rosenberg's (1991) study using humour to regain perspective.

Tariq et al. (2016, p. 3) compared the clinical environment to a pressure cooker, "one that is fraught with emotional or social demands". In such environments, stress and burnout are daily risks. Yoels and Clair (1995) suggested humour can act as an organisational "emotional thermostat" (p. 54), similar to David's mood indicator as seen in my study. Students in the "pressure cooker environment" are expected to manage their workload whilst balancing the needs to learn (learning to care in twenty-first-century healthcare) and to adapt to the emotional demands of daily tragedy, plus juggle a threefold expectation (self, profession and public) of what kind of nurse one becomes whilst achieving job satisfaction. This is the participants' lifeworld and such demands potentially place healthcare students at risk of burnout. Wooten (1996b), speaking specifically of nurses, stated that burnout is often caused by a sense of powerlessness and job-related stress stemming from the emotional labour of their daily tasks. Additionally, White and Howse (1993) reported that nurses suffer from increased rates of suicide, substance abuse and stress resulting in burnout (often characterised, according to Maslach, 1978, by a lack of concern or caring about those around them). Indeed, the students in my study reported encountering RNs for whom the caring has reduced, seen in their descriptions of "robots", "automatons" or the ignoring of PIH (section 6.2.1.2 and 6.2.2.1). Therefore, it is imperative that all nurses develop and maintain adequate coping mechanisms.

Coping with the emotional labour of shorter hospital stays for acutely unwell patients (where pain, suffering and death, or encountering challenging patients, are part of the daily routine) places the nurse's ability to keep perspective at risk (Beck 1997; Mooney 2000). If perspective is lost, the possibility of becoming ineffective as a caregiver arises due to adoption of sympathy rather than empathy – the latter requires the nurse to maintain the objective perspective (Wooten 1996a). Wanzer et al. (2005) and Beck (1997) proposed that the use of humour allows nurses to cope with ever-changing situations: it enables the practitioner to refocus the current circumstances (making them less stressed) by coping with the emotions, trying to solve the problem or distancing themselves from it, as highlighted by Abel (2002). By

refocusing the situation, the day is redefined from a hard one into an interesting one, therefore reducing job-related stress (Astedt-Kurki and Liukkonen 1994). Laughter experienced by nurses allows temporary release from situations which may have become overwhelming (Wooten 1996a). This resonates across the participants' narratives in my study, especially Kellie's: she recounted how, after a traumatic resuscitation attempt, the RN she was working with aided her emotional adjustment (through humour) back to focusing on the other patients on the ward. For healthcare students on a three-year professional journey, there is a need to ensure that they reach the end of their programme prepared to meet the challenges and expectations ahead rather than risking burnout so early in their career and potential apathy towards patients. Therefore, strategies need to be employed to assist pre-registration students, regardless of healthcare profession.

Similar to Wear et al. (2006), dissonance occurred for some students within my study between how more senior RNs acted in a particular manner (for example, adopting a robotic approach) and yet were expected to be their role models. Riley and Weiss (2016) maintained that this cognitive dissonance adds to the students' emotional work since they may be required to perform in a manner ill-suited to their own coping strategies, as seen also in Wear et al.'s study. This may be extended to include how the students in my study (section 6.4.1) had to adapt their own humour usage to meet the mentor's expectations of humour in the clinical setting. The majority of the students in Wear et al.'s study could justify why this happened: it was either a coping mechanism, an outlet for frustration (which arose from the friction between the ideal that their participants felt they should embody and the reality of the clinical environment of RNs mentioned above) or a means of distancing themselves from very unwell people (Wear et al. 2009; Lingard 2013).

In section 7.1, it was established the participants felt strongly about the individuality of their humour, which pre-dated entry into the nursing programme, and how they used humour to cope within their daily lives. Moran and Hughes (2006) maintained that people bring their pre-established coping strategies with them into educational programmes; however, in their study of 32 undergraduate social work students, they concluded no assumption can be made that students entering a healthcare profession have the essential values or strategies to use humour appropriately.

Kubie (1971) implied humour should not be classed as a coping strategy due to the potential destructiveness of it, evident in the use of line 'I was only joking' when unacceptable behaviours arise. Moran and Hughes warned that if humour is the only coping strategy used, then other potentially more appropriate coping mechanisms remain undeveloped. Students require more than humour as a coping strategy. Nevertheless, humour remains a potential strategy to aid student practitioners to cope with the everyday pressures experienced in the clinical environment, meaning they are more likely, by the end of their programme, to be able to tackle challenges and conflicting expectations through the refocusing and managing of emotions.

7.3.2 Influences on the use of humour

The next part of the discussion concentrates on the influences on the use of humour mentioned by the participants. They recognised that humour is a unique human phenomenon and is present across the lifespan. Within the findings, there were strong indications that the age of both the student and the patient played a role in the use of humour.

It is well-established that older people require the majority of bed days within British hospitals, and this is the clinical environment in which this study's participants were most likely to spend the majority of their practice hours. Therefore, they will care mostly for the older patient throughout their nurse education journey, if not their careers. In this study, not only did the participants highlight the power asymmetry within the patient–student nurse interaction (the participants told the patient what to do and when to do it), but also they recounted stories of humour used whilst undertaking intimate acts of care for the older person. Thorson and Powell's (1996) study found that the most commonly used function of humour, by older people, was coping; this may have been reflected in the fact that the older person used humour at this particular time (during intimate acts of care) as told by my study's participants. This draws on Herth's (1993) explanation that ageing is a time of coping and adaption. In Martin et al.'s (2003) study, older women (not men) scored higher in the self-enhancing humour style than younger participants, which the authors suggested was due to life experience and advanced age; meaning, they could cope better. None of the participants in my study who detailed age and its influences on humour use considered humour to be a potential coping mechanism for the older person.

For the older adult, life is not only about coping but also company and, when an in-patient within the hospital setting, they often rely on the nursing staff for this company due to limited visiting hours. This was demonstrated by Belinda's story about the older man who made a joke about her haste. Petzaell and Olsson's study (2007) discovered that the social contact of older people differs according to environment: those within care homes only meet one to two people, usually care staff, per day, whilst those in their own homes meet five to six people per day (this decreased social contact for the older person potentially explains why older people laugh less in the evening or they may go to bed early, Greengross 2013). In addition, older people in care homes have limited opportunities to enjoy humorous exchanges as care staff are required to balance the individual needs of numerous patients against a backdrop of accommodating employers' service targets (Backhaus 2009). By using humour, the older man in Belinda's narrative reduced the social distance between Belinda and himself, which arguable made him more appealing to spend time with, which in turn could have enhanced his care (see section 7.2).

Noted in section 2.5.2 was that older peoples' enjoyment and receptivity of certain humour types changed through their lifespan and their use of humour was influenced by their frailty.

Shammi and Stuss (1999) demonstrated the relationship between areas of brain damage and verbal and non-verbal (cartoons) humour appreciation, concluding verbal humour appreciation was affected in people with right hemisphere damage, whereas in the non-verbal appreciation damage to either hemisphere showed impairment. Across my study's narratives, consideration was also given to the patient's cognitive ability and how this affects the creation and appreciation of humour within the situation. Therefore, the student's ability to decrease the social distance between themselves and the older person through humour is aided by recognising the patient's cognitive ability and their desire for company; this should enable the student to overcome communication barriers.

Participants defined culture as being either a nationality (for example, Asian or British) or a religious group (for example, Muslim). This is in keeping with Nahas' (1998) findings that highlighted cultural influences on humour use and how they can

make things unfunny. The participants, in my study, recognised the influence that ethnicity and culture play when using humour, which may enhance or impede the patient's experience. They also expressed the desire not to be offensive to anyone. In relation to the wider healthcare literature, Dean and Gregory (2005) noted that there is general recognition of how ethnicity can affect the appreciation and effectiveness of humour. One patient in their study stated humour was more difficult when speaking to people of different cultures due to their language. Similar findings regarding language were reported by Olsson et al. (2001); in this study, 20 RNs were asked what humour meant to them. Whilst the participants in Olsson et al.'s study did not offer words usually associated with humour, each participant claimed to have a sense of humour and found their own culture to be the most humorous. Considering my study's minority ethnic students (African), Ethel openly challenged a hostile comment, based on her ethnicity, with her humorous retort, whilst Belinda saw the ethnicity of others as an indicator of understanding, but also as a potential barrier to humour creation and appreciation. Therefore, an understanding of cultural or linguistic influences and how they affect humorous exchanges is advantageous to healthcare students.

In many research studies, there has been great emphasis on how gender influences humour creation and appreciation (Martin 2007). Within my study, gender was mentioned specifically by two participants; however, within the humour narratives there was an even gender split with those with whom they shared humour. From Sylvie's interaction with the male patient and the application of the Conveen sheath, it can be suggested the male patient's use of humour had as its conversational goal the maintenance of a positive self-image (Tannen 1990; Martin 2007) which allowed him to cover up his embarrassment. Ensuring a positive image was a gendered function of humour highlighted in Hay's (2001) study. Romero and Cruthirds (2006) suggested that different humour styles should be used when addressing the opposite sex. Their suggestion was that males, generally, use an affiliative humour style, for example telling jokes and playful teasing (Dyck and Holtzman 2013), whereas women, generally, engage in using the self-enhancing humour style through friendly teasing (Martin 2007). Women, in general humour use, are considered more

supportive, and seek intimacy by using self-disclosure or mild deprecation (Hay 2000; Crawford 2003; Martin 2007).

As noted in chapter two (section 2.5.1), extensive studies focusing on gendered humour's creation and appreciation have highlighted a difference between the sexes' use of humour. The participants' individual humour stories within my study support this, to a certain extent, as they reflect the lists of humour activity and function per gender shown in Table 2.4. However, similar to Hay (2000), both sexes (whether patient/mentor or participant) used different types of humour for different purposes, giving support to Crawford's (2003) assertion that there is no simple gender dichotomy of humour use. This is demonstrated specifically within Laura's uses of sexual humour with both a male and female patient. Using sexually based humour is considered to be a more masculine humour activity, as demonstrated by Hay (2002).

Many of the participants' stories, in my study, were recalled with a smile, under the motto, "you had to be there". This demonstrates the contextual contributions to the use of humour. Cambridge Dictionary's (online 2018) definition of 'context' is "the situation within which something exists or happens, and that can help explain it". Many authors have described how the context of the situation directs the appropriateness and suitability of humour use (Astedt-Kurki and Liukkonen 1994); for example, when staff/visitors laugh near to a critically ill patient's family, this can be perceived as insensitive. This example shows how the situation affects certain people's ability to be near humour. A similar situation arose for Ethel when she heard staff members compare the completion of last offices, for a recently deceased patient, to doing up the "sausage roll": this robbed the patient of dignity even in death. Not only did she voice her dismay at this situation but she also demonstrated her non-appreciation of the humour even though she was not the intended recipient. Over the last ten years, several examples (of undignified care) have been seen in reports, such as Mr Argent who, prior to his death, suffered from a *Clostridium Difficile* infection from which he lost control of his bowels, was left in soiled sheets and was laughed at when he requested clean sheets (Wighton 2011). Such cases represent the worst of contextual humour, yet Leist and Mueller (2013) recommended that humour be interpreted in context rather than simply categorised as either good or detrimental. It may be permissible to use maladaptive humour in

certain contexts since it seems the intent behind the humour use within the context is significant, for example a terminally ill patient using gallows humour to express their fears and anxieties might be seen as appropriate (McCreddie 2008b).

In all of my study's participants' accounts, none detailed how they used planned humour, rather they recounted narratives interwoven with spontaneity. Martin (2007) highlighted that humour is most often unplanned and spontaneous, yet research into the spontaneity of humour in healthcare is lacking (McCreddie and Wiggins 2009). Thornton and White (1999) maintained nurses use humour intuitively, referred to by Dean and Gregory (2005) as nurses using their common sense. This was supported by my study's participants who were adamant that they knew when to use humour based on their pre-existing (to the nursing programme) capacity for humour. Davidhizar and Bowen (1992) detailed how the spontaneity of humour makes it more effective and the humour creator appears less artificial. A conflicting view was offered by Beck (1997) since some nurses from her study routinely planned to use humour within their daily practice as part of the patient's care plan, although she acknowledged that nurses also spontaneously use humour with their patients.

Timing with spontaneous humour use is crucial, especially in a healthcare encounter: Francis et al. (1999) proposed humour fails due to poor timing; Mallet (1993) suggested that humour should not be used in the time of a crisis; and Dean and Gregory (2005) discussed how the patient's receptivity for humour is variable, dependent on their levels of cognition, comfort, relaxation and the severity of their illness. Ridley et al.'s (2014) findings suggested that as patients' illnesses progress, they laugh less. Within the narratives, differing viewpoints on the timing of humour existed: Sonia's use was hindered in times of a patient's acute illness, yet David continued to use humour with a patient and his family until the patient's death. As described in section 7.1, the participants felt it lay within their ability to judge a situation/context and decide the timing and appropriateness of using humour. Consequently, this suggests a student needs to be able to identify their own humour triggers and recognise situations in which humour receptivity may be hindered.

7.4 Students and humour

This study's findings on the experiences of humour added nothing new in terms of humour within healthcare; however, this study does offer the students' voice and their experiences of humour within clinical settings, which has been minimally researched with the UK context. This section focuses on the two dominant aspects arising from the findings: emotional management and communication. These are discussed in relation to this study's definition of humour: *humour consists of amusing communications intended to produce positive emotions and cognitions in an individual or group.*

7.4.1 Emotional management

Foot and McCreddie (2006) maintained that humour is a shared social experience, as discussed in the superordinate themes: the professional journey and the humanity of humour (sections 7.1 and 7.2). These superordinate themes demonstrate the emotional connection the students felt with both patients and mentors. Much has been written about emotions within healthcare. Riley and Weiss' (2016, p. 6) description of emotional labour is "the act or skill involved in the caring role in recognising the emotions of others and in managing our own". This is evident from this study's participants within their narratives.

Within section 7.1, the emotional dissonance experienced by the participants (conflict about when to use humour based on the mentor's opinion) adds an additional element of stress for them. Kinman and Leggetter's (2016) study of 351 student nurses explored the role of emotional expression as a potential resource of emotion-focused coping to offset the job demand of emotional labour. Kaye and Fortune (2001), as seen in this study's literature review, included humour within the repertoire of emotion-focused coping strategies. Two of Kinman and Leggetter's conclusions are of interest here.

Firstly, students drawing on emotional resources were likely to be less stressed but, regardless, emotional exhaustion did increase over time. This concurs with Dwyer and Hunter Revell (2015) who suggested that early career nurses' vulnerability to the emotional challenges of clinical practice places them at greater risk of emotional exhaustion and burnout. Sharples (2018) illustrated increased psychological distress

at two points within her participants' period of nurse education: towards the end of the first year and as they progressed to the end of their programme. This is supported in Cleary et al.'s (2018) integrative review, in which one study (Zhao et al. 2016) proposed a decline in third-year nursing students' well-being. Similarly, Kinman and Leggetter's study suggested that the student nurses' level of emotional exhaustion increased over time.

Secondly, Kinman and Leggetter (2016) suggested novice nurses should develop strategies to deliver care but not at the expense of their own well-being. This is in keeping with the Council of Deans' (2016) discussion paper regarding the improvement of future nurses' ability to cope under pressure through the development of self-confidence and emotional resilience. In Tusaie and Dyer's (2004) historical review of resilience (the ability to 'bounce back'), humour was considered a personal attribute that is associated with resilience. Grant and Kinman (2013) concurred by connecting humour with emotional resilience. Clompus and Albarran (2016) explained that the paramedics in their study used humour as an informal support mechanism which allowed them to manage their emotions. It has been argued that the relief theory of humour is most prevalent as it allows the individual to reframe negative/unpleasant situations into being more manageable on an emotional or cognitive level, as demonstrated in life stories such as in Frankl (1992). Additionally, resilience has been considered a process that is learnt which can aid the ability to understand another's point of view. Therefore, it can be said that using humour as a social vehicle increases the students' social competence (Reyes et al. 2015; Aburn et al. 2016; Cleary et al. 2018).

Aburn et al.'s (2016) and Cleary et al.'s (2018) integrative reviews on resilience expanded the concept, beyond the ability to 'bounce back', to include: overcoming adversity, adapting and adjusting, being a protective mechanism against mental health disorders, maintaining equilibrium, retaining control and dealing with external stressors. Cleary et al. maintained resilience is closely linked with emotional intelligence. McGhee (no date), reflecting upon emotional intelligence definitions, identified key areas of consideration for the basis of any strategy aimed at emotional intelligence development: self-awareness of one's own emotions, self-management (regulation) of own emotions, motivation, empathy and social skill. Using humour as

part of self-resources to build upon emotional intelligence was identified by McGhee as being included across the wider healthcare literature.

As noted above, resilience is a multi-dimensional concept; therefore, it requires a multi-directional approach. This approach can be based on the development of both personal and social competencies: emotional literacy, critical reflection skills, accurate empathy, social competence and social support (Grant and Kinman 2014). In their edited book, *Developing Resilience for Social Work* (2014), Grant and Kinman offered solutions for each element; however, these need to be adapted to suit nursing clinical practice and the number of students within large cohorts such as adult nursing.

The cohesive nature of humour is not only applicable to patients and mentors but also to the students' attempts to integrate into the practice placement teams, as Fine (1983) suggested humour plays a role in establishing a sense of community. Due to the rotational nature of their programmes, nursing students are constantly trying to integrate into new teams. They form part of the wider nursing team but do not belong to either the nursing assistant team or the RN team, which is the group they aspire to join. One's status within a team can, through the use of humour, shift from that of an outsider to an insider, which gives a sense of identity and group cohesion (Fine 1983; Martin 2007). Students strive to achieve this sense of identity especially with the RNs and, through using humour, can establish a bond that reduces the social distance between them, helping to expend minimal emotional energy (Reilly 2006; Martin 2007; Romero and Pescosolido 2008).

By establishing the position of an insider, one adopts the group culture; therefore, humour (for example, irony or satire) can enforce norms which can reinforce the status of a student within the team (Fine 1983; Martin 2007). The positive use of humour within the team lubricates the interpersonal communication in situations which may be demanding or awkward, enabling the individual to cope, and it increases group productivity and effectiveness (Romero and Pescosolido 2008; Mesmer-Magnus and Glew 2012).

The participants within my study had mixed success integrating into the various teams of their clinical placements. They often expressed that their exposure to

negative uses of humour left them feeling disempowered, highlighting the ambiguity of humour and its power. Using their emotional energy to integrate into the various placements leaves the students vulnerable, especially if they are prohibited from using humour through the quip 'it's unprofessional'; this reduces the availability of coping strategies, which can lead to the students' emotional exhaustion.

Therefore, the student's emotional management skills must be enhanced, thus enabling them to cope and balance the modern-day technological expectations of healthcare whilst remaining human.

7.4.2 Communication

Throughout this discussion section there have been several positive applications of humour acting as a social lubricant in social interactions. Students' experiences were either on an individual or group level. According to Martineau (1972), social interactions constitute the everydayness of social routine and order; using humour as a social lubricant can initiate these social interactions and keep interactions flowing, thus maintaining harmony and stability (Martin 2007). Martineau continued that the abrasiveness of humour can act as an obstruction to the flow of social interactions. Therefore, for Martineau, humour within social interactions performs the following functions: promotes cohesion, provokes conflict and provides control (to which Foot and McCreaddie (2006) add: "searches for and gives information"). Although each function is evident across the various discussion sections in my thesis, promoting group cohesion is the one which resonates with humour as a social lubricant, as noted in this study's concept of humour.

The use of humour as a cohesive agent and its positive effect on those involved in the humorous exchange can be seen particularly within the participants' stories involving patients. Reilly (2006) maintained that humour can be used either in an affective or cognitive manner to obtain that positive effect. According to Reilly, it is this positive effect relieving tension and anxiety which produces an atmosphere of spontaneity and flexibility (discussed in 7.1 and 7.3) since this ensures psychological safety for the students, meaning they might be willing to take risks and face conflict within the safe team climate (Romero and Pescosolido 2008). Reilly concluded that it is in an atmosphere of flexibility and optimism that the creativity of learning grows;

this in turn influences the development of a practitioner's expertise. It is the lubricating role of humour within interpersonal relationships with patients and mentors which encourages the student to learn to problem solve. Therefore, there is a role for humour to play in nurse education as it promotes environments that are conducive to learning. Then, due to this increase in flexible creative thinking and problem solving abilities, it can be suggested the student would be able to better discern if and when to use humour (Romero and Pescosolido 2008).

Throughout the discussion, the multidimensionality of humour and nursing has become apparent and it can be a minefield for the novice student nurse to negotiate. From a critical realist perspective, I must look towards the real world and identify the underling generative mechanism: power.

7.5 Emotional management strategies

Areas of development and application which need to be considered within nursing curricula are strategies to assist the student with the management of their emotions and the building of resilience within the clinical setting. This is an important part of an educator's remit and the following section deals with how this can be implemented. The strategies outlined below, include areas of practice where this thesis' output (section 7.6) can be utilised.

Any developed strategies should be considered from both an individual and organisational perspective. It is not within the remit of this thesis to offer organisational solutions; however, Grant and Kinman (2013; 2014) suggested stress management training (for example, Mindfulness), using organisational resources (for example, counselling services), and effective support and supervision.

Grant and Kinman (2013; 2014) considered the term 'emotional literacy' to be more appropriate in healthcare settings since it consists of both intrapersonal and interpersonal competencies. Concentrating on the intrapersonal elements, they suggested aspects of this include an individual having the ability to pay attention to their own feelings and to be able to 'repair' them (by recovering from negative moods or prolonging positive moods), followed by the ability to identify certain emotional

experiences. In order to do this an individual needs to be equipped with self-knowledge (Kinman et al. 2014).

Critical reflective ability has been described by Grant and Kinman (2014) as offering an alternative solution, as reflection enables the practitioner to either adopt another approach or intervention. This would entail the students understanding their own humour triggers and so having the ability to deconstruct a situation of positive and negative humour experiences, with associated emotions. Grant and Brewer (2014) suggested clinical supervision, to aid reflective practice and also learning. For them, reflection is self-protective since it allows exploration of emotions, feelings, reactions and pre-conceptions. Utilising a one-to-one supervisory relationship within clinical practice is not currently feasible; therefore, I would suggest the following: ward-based or year-based student support groups for a day, or a minimum of two hours, away from the clinical placement. These could be facilitated by the academic supervisor (NMC 2018). In the past, I have implemented such student support groups, which were evaluated well by the participating students, although the focus of these support groups was clinical topics (patient assessment, principles of aseptic non-touch technique, etc.). The groups provided a safe platform for the students to discuss and reflect upon their own practice in a secure environment (Flynn and Kane 2009). Kinman and Leggetter's (2016) study supported such interventions as they maintain opportunities for 'emotional venting' (p. 7) and social support is an effective resource for stress management. Future research topics could include exploring the strength of student nurses' emotional reactions or the importance of emotional self-care for student nurses.

Within the academic setting, clinical supervision could be guided by the personal tutor, either on a group or individual basis, as this should increase the students' self-knowledge (awareness of own behaviour drivers, strengths and limitations), which in turn would increase their awareness of situations that jeopardise their well-being (Kinman et al. 2014). An additional useful technique could be using more creative elements such as emotional writing interventions (Kinman and Leggetter 2016), for example students engaging with patients' life stories with a focus on empathetic reflection or reflective communication (Grant and Kinman 2013).

From a clinical perspective, another strategy would be to introduce an emotion check to the safety huddle. Codier et al.'s (2013) mixed methods study of an emotional intelligence check round (staff were asked to identify emotions experienced by other staff members and patients and what coping strategies were being used, then a discussion followed) detailed how the authors expected the oncological nurses to be able to recognise emotions in themselves and their patients, but this was not the case. However, post intervention, they did note emotional care planning had increased. Therefore, it can be suggested that beginning to understand the role of emotions within daily clinical practice will improve the students' self-care and improve emotional care of the patients.

The above strategies (critical reflection, supervision and emotions check) should enable the students to begin to adopt accurate empathy: a combination of empathetic concern ("feelings of warmth, compassion and concern for others") and perspective taking ("attempts to adopt the position of others") (Grant and Kinman 2014, p. 27). Both of these elements of empathy have been linked to affiliative humour use (Davies 1983; Hampes 2001).

Support, both from academic and clinical sources, has often been discussed as being a resource for students (Baker and Jones 2014). Many clinical areas are beginning to implement team mentoring models, such as CLiP (Collaborative Learning in Practice) (Lobo et al. 2014). This utilises peer mentoring, which entails a mutually beneficial relationship built on equal status, respect, trust and cooperation (Baker and Jones 2014). Using structured tools such as GROW (goal, reality, options, way forward) enables coaches (senior nursing students or RNs) to provide feedback for the person to reflect upon (Baker and Jones 2014). This could assist students in balancing the tripartite expectations of what an RN is and reduce their vulnerability as they would not be working towards one person's definition of professionalism.

7.6 The thesis' knowledge contribution

Robinson (1977) mentioned that in order for nurses to develop humour as a spontaneous communication pattern, within the professional environment, they need to consciously and deliberately exercise it. Based on my findings and the previous literature, I would propose here that, for nursing students to consciously and deliberately exercise humour, they must have an understanding both of the different

types of humour and of the wider considerations, such as their own humour triggers (and humour responses), as well as an understanding of the audience responses.

All of the participants within this study demonstrated that they could recognise and appreciate humour, thus they had some understanding of their own humour. However, they experienced disagreement over their use of humour in addition to their non-agreement with some of their role models' lack of humour use; this created an emotional and professional conflict for them. For the participants, humour was a feature of themselves which arose out of the interaction between the parties involved and from the situation.

In order for students to create a deeper self-awareness of their own use of humour and increase their own humour awareness, it is necessary to facilitate a more conscious recognition of their own humour triggers (and the associated emotions) and of how their humour use unfolds within a social interaction. Bakker and Heuven (2006) argued that by developing introspection through reflective practice any emotional dissonance can be offset. Therefore, a need exists to develop a reflective tool to assist with the development of humour awareness.

To this end, the original output of this study is the humour awareness compass (HAC) (Figure 7.1), which is based in part on Stigel's (2008) typology. The HAC is the product of humour theory application and brings together the components of humour discussed throughout this thesis.

It considers:

- the setting up of the humorous occurrence
- influential individual lenses on one's humour use
- the types of humour
- the cognitive input required to recognise, understand and appreciate a humorous occurrence
- the power asymmetry of humour use (affiliative/disaffiliative) based on laughter (intent)
- humour support strategies involved in the humorous occurrence
- the audience responses to humour use.

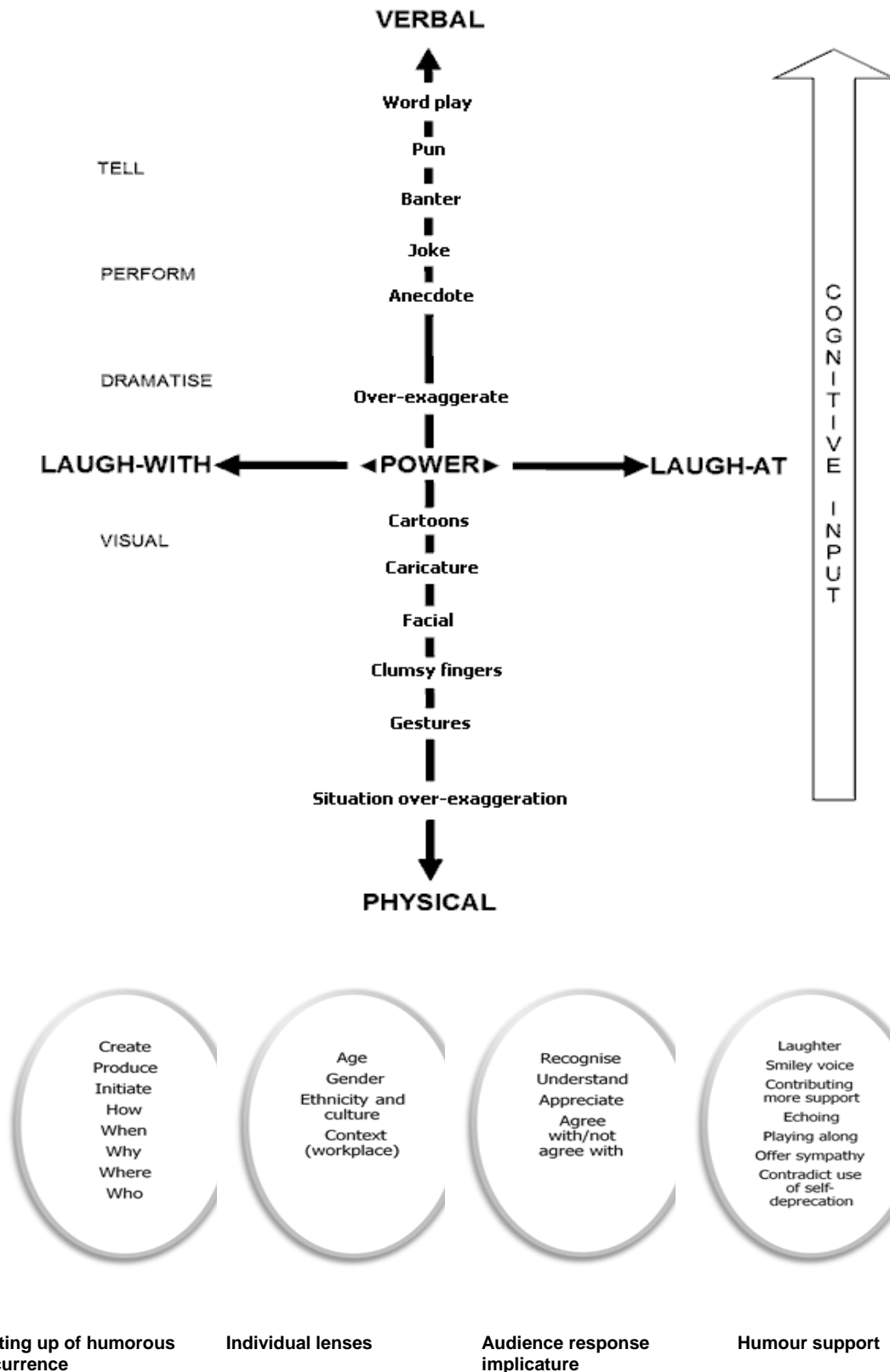


Figure 7.1: Humour awareness compass

Figure 7.1 presents a two-axis representation of power asymmetry (horizontal axis) and modes of humour and associated types (vertical axis): physical, visual, dramatise, perform and tell (verbal) – in ascending difficulty, that is, requiring more audience cognitive input to appreciate the humour.

The suggestion would be this figure contains the various humour theories as no one theory can claim to be universal. Along the horizontal axis, one would find both the superiority theory and the relief theory. If the intent is to relieve stress then you would be ‘laughing with’ or if the intent is to ‘get one over on another’ then this lies towards ‘laughing at’ someone. Then the vertical axis is the representation of both the cognitive and linguistic theories seen within the difficulty of humour used, such as joke construction.

To use the HAC, a person begins by looking at the interaction: firstly, who initiated the humour occurrence (the setting up)? Secondly, what influences may affect the humour occurrence? Thirdly, identify the type of humour used, along with the cognitive input required to recognise, understand and appreciate the humour used. Fourthly, move to the intent (power asymmetry) behind the humour use (affiliative/disaffiliative). Lastly, extend the focus to other forms of humour support and the audiences’ response to the humour use.

It is proposed here that, by using the HAC as a reflective tool to aid in the deconstruction of a humorous experience with patients or role models, the students could develop a more holistic understanding of their own humour triggers, especially when conflicts arise. Developing these elements of reflective practice can link into intrapersonal and interpersonal competency growth, which in turn can increase one’s emotional intelligence.

Belinda’s example of the older and younger patient can be used to provide an illustration of the use of the HAC. She could start by deconstructing the interaction, firstly by deciding who initiated the humorous occurrence (according to her narrative, the patient). Then she could evaluate the wider situation and consider, for example, the timing of the humorous interaction and with whom it occurred. Her next thoughts could consider any influencing factors (such as age, as she described how older patients preferred certain types of humour) that would have affected her use of

humour. Then she could judge what types of humour were used (word play), the cognitive input required and the intention behind them (the older man's use of humour was based in the superiority category, as he degraded younger people and their haste; however, she recognised he had masked within his humour a need for attention). Then her attention could turn to her audience's response (in her case, she did recognise, understand and appreciate the older man's use of humour, as the fact she responded demonstrated her appreciation). It is here she could begin to understand the problematics of certain types of humour use, an understanding which hopefully would enhance a patient's care. (From her example, I cannot illustrate the support she gave for the patient's humour, nor state to what her level of appreciation or agreement was.)

By developing these humour skills she could gain a better understanding and enhanced knowledge of her relational skills to use within her clinical practice. It is expected that using the HAC to develop her humour awareness would enable her to identify potentially harmful situations for the patients, such as the one eluded to in 6.2.1.3, which could lead to her reporting her concerns to more senior members of the team. Utilising the HAC is an area for future research, as discussed in chapter eight.

7.7 Conclusion

The findings of this study have been discussed with reference to the wider healthcare humour literature. Communication and emotional work and management were highlighted as the two main areas of attention. Recommendations for emotional management from a clinical perspective for pre-registration students were identified.

The next chapter concentrates on my reflexive conclusions, contributions to the existing healthcare literature, limitations, recommendations for a wider audience and future research opportunities.

Chapter 8: Conclusions and recommendations

This chapter summarises the research undertaken, and my reflexive stance of this study is considered. Additionally, it indicates this thesis' contributions to the humour-within-healthcare literature, followed by an evaluation of this study's limitations. Finally, practice recommendations and potential future research are outlined.

8.1 Summary of the study

This study used interpretative phenomenological analysis (IPA) to explore pre-registration nurses' experiences of humour use within the UK clinical setting. Ten nursing students (nine from the Adult field of nursing and one from the Children's field of nursing) were interviewed, either at the university or in their current placements, from May to December 2014. Interview recordings were professionally transcribed verbatim and analysed following IPA guidance.

By using IPA, this study highlighted a dissonance between what the students thought and said about their own humour (especially its value) and their usage of it: they were willing to adopt behaviours (forgoing humour use) to avoid a conflict with their mentors, despite believing that humour could potentially be used to alleviate pressure or stress. This necessitated further exploration into student–mentor and student–patient relationships. A benefit identified was the participants' use of humour with patients and how it enhanced relationships with them. Individual idiographic accounts were described which then progressed to a group-level analysis. Interpretations of the students' experiences sought to explore meaning, and these findings were integrated with the wider humour literature, inclusive of humour theories. Three superordinate themes were identified: 1) the professional journey, 2) the humanity of humour, and 3) humour influences and characteristics. In regard to humour acting as a social lubricant, recommendations in the following areas were highlighted: emotional management and communication. Finally, a humour awareness compass (HAC) was proposed, based on humour types and laughter

8.2 Demonstrating reflexivity

Within the qualitative tradition, reflexivity is a key element of research (Shaw 2010). New knowledge production is a co-creation (between the researcher and participant) of the interpreted facts and previous knowledge (interpretation and understanding) (Probst 2015). For Horsburgh (2003), reflexivity refers to:

Active acknowledgement by the researcher that her/his actions and decisions will inevitably impact upon the meaning and context of the experience under investigation (p. 308)

Clancy (2013) detailed the fundamental need for reflexivity to be an active process, the gaining of self-awareness in order to help identify any influences on the data collection and data interpretation stages. Sloan and Bowe (2014) considered the added value reflexivity can bring to the interpretative stages.

Reflexivity occurred throughout my journey and is presented here metaphorically as a pregnancy. It is ironic, as I identify strongly as an Adult nurse, to encase a reflexivity process in this way. It seems apt as both journeys (midwife and researcher) were fraught with new challenges and responsibilities. This section draws on my prologue, reflexive journal, supervisions and previous chapters.

The writing of my prologue aided me to identify some of my preconceptions regarding humour in clinical practice, based on my personal and nursing experiences. Finlay (2009) and Smith et al. (2009) recognised tensions between a researcher's preconceptions and the significant role the researcher plays in the interpretative stage. Smith et al. (p. 6) cautioned that preconceptions may be "an obstacle to interpretation", whereas Finlay (p. 13) maintained they can be "exploited as a source of insight". Writing the prologue permitted me to revisit my training days and to realise how I was trained to be emotionally detached and how my thought processes were black and white, and limited to the narrow field of Adult nursing. Some preconceptions arose within the interpretation phase, but these were discussed within supervisory discussion and the presentation of my findings at Cardiff University's Research Symposium (2015).

Using an audio reflexive journal helped me to write my thoughts on ongoing methodological issues and my development as a researcher. Clancy (2013) noted

that a reflexive journal allows for deeper questioning so that transparency of the researcher's influence on certain areas (such as decisions made or concerns arising during the implementation of the research study) can be documented.

Doctoral supervision and annual review monitoring were processes in which I was able to discuss and reflect on my research study in an environment of support. These allowed me to demonstrate the robustness of the decisions I had made.

Presenting my study's findings at both Cardiff University's Research Symposium (2015) and the Milton Keynes University Hospital Mentor Conference (2015) allowed me to revisit my initial findings based on feedback from fellow nurse colleagues and researchers.

8.2.1 The conception

This phase begins with the conception of my idea into a proposal, since I wanted to investigate the phenomenon due to my own journey and the influence and meaning humour has had for me across my international experiences. However, framing the idea appropriately within the philosophical framework aligned to my viewpoint required time and took several attempts to achieve a satisfactory outcome.

From my prologue it became evident that what drives me is both an acknowledgement that disempowerment is unacceptable and a belief in fairness. Features of this stage were my impatience at wanting to start and being hampered by the need to think about a philosophical framework.

8.2.2 The first trimester

The first trimester dedicates itself to the process of gaining ethical approval and recruitment, as well as coming to terms with being a doctoral student (with its prestige and the unpredictability of the research process). Here, it was the waiting which wreaked havoc with my resolve to keep the momentum going.

Recruitment efforts detailed within my journal highlight the length of time taken to complete this stage, for many students indicated their willingness to be interviewed but did not reply to my follow-up emails regarding their availability (methodological limitation). In addition, several audio entries in my reflexivity log detail 'lightbulb' moments when I began to understand the difference between ontology and

epistemology; this was the beginning of the challenge to my black-and-white thinking.

Features of this trimester related to my own insecurities as a researcher: I always seem to think I am not good enough, especially when listening to colleagues talking about their doctoral studies. My lack of self-confidence surprised me as I do consider myself to be a confident person.

8.2.3 The second trimester

The second trimester is the actual data collection period, and I felt awash with success and felt like a 'real' researcher invigorated by the participants' willingness to share their time and stories with me.

Table 5.5 is an example of my reflexivity during the interview phase of this study. This highlights decisions made based on my deliberations about the interviews undertaken.

Another point of consideration from my reflexive log is my examination of the balance, in the interview, between the participant's voice and my own: I questioned whether I was speaking too much. The self-doubt crept in about my participant's voice not being heard within the interview; therefore, I used Kvale's (2007) criteria to answer questions on my interview technique in order to ensure that the participant's voice was being privileged.

Crossing the line between insider/outsider (the role confusion of me being a nurse teacher or researcher) was something I had to be aware of as, I worked not only as a link lecturer for several areas the students were placed in, but also as a unit lead for their programme. However, I shared a common professional bond and identified with the students, which offered insight into what they were talking about (Clancy 2013). After this, using my audio reflexive diary, I talked about my own feelings about how the interviews went and what impression I gained. My main learning curve here was the need to use my interview schedule more flexibly.

Features of this trimester were the generosity of the students and the privilege I felt as they shared part of their journey with me. The metaphor moves onto the third trimester: feeling bulky and you do not really know what to do with yourself.

8.2.4 The third trimester

The third trimester is the data analysis and writing up: bulked with reams of data, not being quite sure where to put it, fraught with emotional outbreaks of self-doubt and pity, and wondering why I chose to put myself in this position. I am using these paragraphs to gather my thoughts about the (potential) influence that I, as an individual or registrant or nurse educator or novice humour researcher, had on the steps of this study. Using Yardley's (2015) criteria assisted in structuring this part of my reflexive section.

During convalescence, following an operation and an approved sabbatical, I had the time to 'empty my mind' and concentrate solely on my analysis. Before commencing this analysis, I considered humour to be something that is individualistic, makes people feel better and binds people (my parents). This was based on my lay knowledge of humour as a positive phenomenon and my own negative clinical experiences. These showed the polarity of humour; therefore, I looked for this within the analysis to create a balanced view (which is part of who I am – a seeker of balance). This meant that when I came to analyse the participants' stories (data), I had to ensure that I did not impose any pre-conceived ideas onto them. Being aware of not imposing pre-conceived categories or ideas that could potentially arise from the writing of the literature review was important to me, so I chose to write the literature review after my analysis was completed (although up until the submission date, this was ever evolving). Being open to other people's experiences of humour was important and knowing that their humour journeys would be different was exciting as it made me think beyond my current knowing. So, to be open, I treated each account individually. This in part was driven by me wanting to be fair. To achieve this, I often spent my time walking my dogs and talking into my audio diary about my thoughts and my conclusions – for example, I spent quite a while thinking about individual words such as "robot" or "abuse", and what meaning they had for the participant within their current context as a student nurse. This enabled me to prepare for the next interview analysis. This would conclude Yardley's first criteria: being sensitive to the data and the socio-cultural perspectives of the participants.

Spending, sometimes, a week on one interview allowed me the freedom of time to consider various possibilities of meaning generated by the participants, either

through their humour stories or in their replies to my questions. I was surprised at how often I felt engulfed by (immersed in) the participants' accounts and how I visually tried to connect themes. I considered this to be telescopic in nature as I was forever zooming in and out. Alternatively, as in Kvale's (2007) example of being a miner, I dug into the mountain of words within the interview and later, after the interpretation, emerged with smaller piles of gems that would become the themes. It was the example of the miner that I used to explain the analysis stage to my parents; this metaphor they understood as Johannesburg was surrounded by many slag piles. So, telling them I was sifting through the interviews by breaking the whole into parts (as the gold mines had started to refine the slag piles) made it understandable for them but also me, as I was looking for pieces of strains of gold (gems) within and across the interviews.

My self-doubt had the potential to restrict the analysis from being intuitive with the data or going beyond a descriptive interpretation, hence why I attended so many workshops and kept checking what Smith et al. (2009) described in their book. Initially, the depth of interpretation achieved was, for me, not satisfactory; therefore, I started again. I consider myself 'a plodder', so breaking each step of the analysis down enabled me to move beyond description. After reading McCreddie (2008b), I realised it was the analysis of the humour that the participants described in their humour stories that was required. This led me to re-analyse the stories for the kinds of humour I had been reading about in preparation for my resubmission (Appendix 4). Perseverance (personal commitment) has been a constant theme within my academic career and one of my strengths used consistently throughout the analysis stage. The above demonstrate my commitment and rigour to the IPA method of analysis.

During the interpretation phase, I questioned my own thoughts of professionalism and how the mentor and organisational culture influenced the students' use of humour. I developed an interest in linguistics, often an area which I shy away from due to my own perceived limitations when using the English language. It is the 'becoming' of a professional that intrigues me, as well as the multiplicity of influences on a student nurse.

I was surprised by the strength of the visual metaphors conjured by the participants' narratives as I do not tend to think of myself as creative. Listening to other people's stories made me think of my own and those of the many people who have passed through my life as well as the associated struggles of being a novice nurse, now replicated as a novice researcher. Being honest with oneself about vulnerabilities and capabilities is a common theme throughout this thesis and can be considered one aspect of transparency (for me), as these influence each step of this study. Knowing when one requires help, such as me using a proof-reader, or a willingness to forfeit six months of analysis work as the data yielded minimal returns (statistical analysis) can be considered examples of transparency and ensuring the thesis is presented in a coherent and cohesive manner. Additionally actions such as taking the time to transfer my paper notes into electronic sources (chapter five and Appendix 6) are intended to enable the reader to follow clearly how the interpretation is derived from the participants' interviews.

The fourth of Yardley's criteria is the study's impact and importance, or its "so what" (p. 268). For me, the "so what" is building upon McCreaddie's work as the CNSs within her study were once student nurses who used humour.

This concludes my short narrative, incorporating Yardley's four criteria, on my influence on this project.

8.2.5 The 'birth'

The birth of my thesis is the emerging of the final product, the fruit of my labour sat at a computer for many hours, fraught with pain and misgivings about if I will ever get there. Reflections from this phase are my fear of having to be an expert in any section of this thesis and the need to tackle so many philosophers from the perspectives of humour and IPA. The latter limitation also had a positive effect as it empowered my own thought processes to move beyond black/white to multidimensional thinking. The sense of growth that occurred within me during this process feels invisible and yet I surprise myself when I answer a question on this topic.

8.2.6 The 'baby'

The presentation of the 'baby' is the viva; the feelings are paradoxical due to the delight of being finished versus the insecurity of thinking whether my work is good enough.

8.2.7 Growing the 'children'

One can also draw the analogy of growing the 'children': sustaining the momentum and nurturing the post-doctoral work in the areas of humour, or perhaps putting my own recommendations (below) into action.

8.3 New horizons: contributions to the humour-within-healthcare literature

To date there is a plethora of humour research based on healthy individuals in controlled settings using rehearsed humour interventions such as comedy videos (McCreaddie and Payne 2011). Furthermore, humour research in clinical settings predominantly included registered HCPs or patients as participants, not student nurses. Some studies, such as Fontaine (2011), included student nurses as part of a larger sample, and such students have been the focus in a different context, for example in the university/classroom setting (Struthers 1994).

Using IPA offers a novel insight into the students' everyday lived experience of humour; however, multiple interpretations of any phenomena can exist. The combination of nursing students as the population of interest, humour as the phenomena of study and it all being conducted within the context of UK clinical practice is an original contribution – no such study was found in the extensive literature search. Communication and emotional management strategies do feature often within nursing literature, although largely in relation to practice. Therefore, the contribution of this study is the exploration of the student's perspective, including the contradiction between the values a student is recruited for (which can include humour and the worth the students place on it) and the role modelling of such values amongst the registered staff, which adds to the student's stresses of trying to become the nurse they want to be.

8.4 Limitations

One limitation of the study is that my status as a novice researcher is imbued with difficulties. One such difficulty was understanding the numerous philosophers involved both the phenomena (humour) and my methodology (IPA). By attending various IPA sessions and reading widely I began to unpick the significance of each philosopher's contributions to their respective fields. Another limitation would be having nursing students (predominantly Adult with one Children's field) from only one university.

The next limitation associated with my novice status was made evident by the interviews: they were short in comparison to Smith et al.'s (2009) recommendations. However, whilst my interviews were temporally limited, they nonetheless produced a level of richness within the timespan allocated by the student. This is indicative of a certain quality of interview (Flowers and Dickinson 2017). I did seek to extend the discussion by offering the participants more time towards the end of each interview; however, due to the power asymmetry within our roles in the organisation, I did not 'push' when they signalled "that's all" and "that's enough".

As previously mentioned in chapter five (section 5.8), I choose to privilege my participants with my attention, so completing my reflexive notes afterwards could have detracted from the quality of the data. Additionally, I often had to stop myself being caught up within the topics being raised, whether as an avid listener, RN or nurse educator.

Another potential limitation is the single source of data collection; McCreaddie (2008b) advised the complexity of humour necessitates multiple data collection methods. Further noted could be the limited application of the humour theories to the findings; McCreaddie (2008b) expressed disappointment that most humour studies in nursing research ignore the humour theories. However, McCreaddie (2018) cautioned that using self-reported data can be analysed naively if drawing comparisons between groups of differing seniority – for example, comparing experienced CNSs to senior student nurses. She recommends being more careful, especially when endorsing humour initiation.

An additional limitation of this thesis could be my writing style and use of syntax. Smith elaborates, in his example of Linda's transcript, on the linguistic analysis of tenses and how this impacted on the final themes (Smith et al. 2009). Such linguistic analysis lies within the researcher's ability to recognise the various tense forms, which often eluded me. Therefore, within the linguistic interpretation of the data analysis, some tense interpretation may have been lost. Smith (2008) expected novice researchers, such as I am, to achieve at least the second level of interpretation, which means reaching beyond the initial cautionary analysis based solely on the description of the participants' narratives (Smith et al. 2009). The interpretation phase also contains the limitation of using the participants' stories as a base of information. These could be called anecdotes, which McCreaddie (2008a) pointed out become rehearsed stories with each narration and the spontaneity is lost. I would rationalise this study is about the students' experiences of humour and these stories represent these.

Timing was a limitation in the following areas: firstly, the timing of how the study's phases were executed potentially could have compromised its integrity, as explained in chapter one; secondly, the experiences of the students, particularly the senior students, earlier in their training may not have been accurately presented by them because they could have been 'tainted' by later experiences; thirdly, the students' views of humour may change across their careers due to the multifactorial influences (as outlined in the literature review and discussion), so these findings remain only a picture of one moment in time, especially as nurse education and the role of the RN is set to be radically reformed (NMC 2017); and fourthly, some of these participants were involved in colleagues' research projects, which could have led to research fatigue for them.

One potential methodological limitation is the length of the recruitment stage. The small sample size might also be considered a limitation if attempting to generalise the findings from ten nursing students to the whole UK-wide student nurse body, although this was never an intention of this study nor is it an aim of IPA. However, I would consider this study to be the beginning of a body of work focused on the wider population of student nurses and the spontaneous use of humour in the clinical setting.

Lastly, the missed opportunity to explore peer to peer (student nurse to student nurse) interactions, as no interview question about this group was posed, could be a limitation.

8.5 Recommendations

Various themes and topics have arisen from this study, many of which are already dealt with in the humour literature involving RNs. The following recommendations are to enhance the pre-registration HCP's journey based on areas of policy, practice and education.

From a policy viewpoint, a wider-encompassing recommendation would be to extend the current 6Cs of nursing (DH 2012b) to 7Cs. The seventh 'C' could be 'chuckle' or 'cheerfulness' because, as all too often as noted throughout this study, nurses more often chose not to laugh with their patients as they deemed it to be unprofessional. With official sanctioning, the acceptance of humour into the professional arena is significantly progressed and almost guaranteed.

From a nursing practice perspective, nursing students are faced with daily tragedy and the contradiction of experiencing people who embody the dissonance between the ideal of values placed on students and the reality of clinical practice. In order to address the students' ability to cope with this, I recommend the introduction of an adapted Schwartz Rounds for healthcare students (adapted due to cost). Ensuring this is inter-professional would make each healthcare profession student realise it is a common theme (Grant and Kinman 2014). Such rounds would be used to create a safe environment in which discussions about professional humour within the clinical setting can occur, which ultimately may enhance a student's ability to be more receptive to patient needs (Dean 2017). Schwartz Rounds is a well-known concept from the USA aimed at increasing compassion within healthcare interactions (Gishen et al. 2016). Francis (2013) recommended the adoption of such rounds to create positive change. Gishen et al.'s (2016) pilot study involving medical students in Schwartz Rounds suggested that the final year students profited most from these discussions as they were more concerned about compassion fatigue or burnout than junior colleagues with less clinical experience.

Highlighting the need for emotional management through connecting with emotional resilience would allow student nurses to recapture the art of nursing. This would allow them to draw together the personal and professional self. This enables their pre-capacity for humour to be channelled into their ethos of care in the form of an advanced communication skill. An emotional management strategy, as proposed in 7.5, would focus on the emotional situations of clinical practice, which are labile, and the student's ability to cope. It would increase their self-esteem and estimation of the own abilities by making them realise they have the power within themselves to be good RNs. It is hoped that such a strategy would help RNs embrace the use of appropriate humour within the clinical setting and so open up the possibility of not hearing 'it's unprofessional' when students are heard laughing with patients. This aligns with the Council of Deans (2016) proposal for an emotionally intelligent curriculum.

From a mentoring perspective, the mentor updates I delivered within NHS partners contained a discussion about 'being professional'. Using Hammer's (2000) wheel of professionalism, a deconstruction of behaviour and underlying attitudes was possible, for example explaining take-home medication to the patient with the image of a bicycle wheel: the tyre is the observable behaviours (language used to explain the medication, and body position and posture) of the student/RN. The spokes are the underpinning elements of the interaction – if the student uses lay terms to explain the medication, they are being inclusive towards the patient. They are also showing the patient respect, as the aim is to empower the patient by providing the information so that the patient can make an informed decision. The centre of the wheel is the core personal values of the student, which drive their practice ethos.

Another point of consideration, in nursing practice, is the mentoring process: Hunt et al. (2016) noted that student nurses are using disparaging strategies (belittle or denigrate), aimed at their mentors, especially if they are underperforming. Such disparagement could be extended to include disparaging humour. This type of mentor disparagement should cease with the NMC's (2018) vision of group mentoring being implemented from 2019.

Considering the patient perspective, for the service users that cannot express or communicate their humour needs I recommend an additional section be integrated in documents such as 'This is me' (Alzheimer's Society 2017) or healthcare passports for those patients with learning disabilities. This should enable the healthcare team to communicate with the service user on a more personable level.

8.5.1 Education

From an educational stance, for most people, humour is personal and has no formal definition. I propose a series of lectures revealing the multiplicity of humour. The series would include such themes as the philosophy of humour; its influences and types; how to use the humour awareness compass; humour and coping; halting the emotional decline; and humour and patient care.

The focus of nurse education is unfortunately on the bureaucratic definition of nursing rather the professional (Maben et al. 2006). One of the most distinguishable aspects of a professional nurse is that they rely on evidence and expertise rather than rules and regulations to make decisions. Professional nurses focus on holistic care based on individual patient's needs and exercise professional autonomy to execute independent decisions based on their knowledge, as well as their willingness to exceed expectations. Conversely, bureaucratic nurses rely on rules and regulations and exercise autonomy based on their position within the organisational hierarchy. They also present an uncaring attitude as physical care needs take precedence over psychological needs (Maben et al. 2006). The implications of this are that role models need additional support to re-engage with the ethos of professional nursing; this could be delivered through the revalidation process.

The role that nurse lecturers and mentors both have in the development of student nurses and their responsibility for assessing the student's academic performance and their performance in clinical practice, respectively, need to be considered. It is here implications for lecturers/mentors concerning nurses' education can be found: less emphasis could be put on the processes of assessment and accountability and more emphasis could be placed on the development of the art of nursing and the emotional tension students endure – for they are not only learning their craft but dealing with emotions they may never have experienced before. There are current

calls for additional mental health support for student nurses due to an increase in student suicides (Nursing Standard 2018).

Each individual student's pre-existing capacity for humour, the role models along their journey and the feedback obtained on their use of humour will shape their own ideas of humour within the professional sphere. Their forthcoming experiences, as RNs, will assist them in the decision of whether or not professionalism and humour are mutually exclusive. It was McCreaddie and Payne's (2011; see also McCreaddie 2008a) conclusion that using humour is professional and worth the risk, which echoes my sentiments as a nurse educator and RN with several years clinical experience. Additionally this conclusion resonates with the thoughts shared by the most senior student participants of this study.

8.6 Further research opportunities

Numerous opportunities for future study regarding student nurses' perception, experience or endurance of humour within UK clinical practice have been identified. Possibilities include mapping students' changing use and content of humour over the three-year programme by establishing their pre-entry humour, or studying how mentors and students – or students and patients – use humour in clinical practice (potentially utilising longitudinal or observational research designs). Another opportunity would be to repeat this study with an extended sample group (from all fields of nursing) and other universities within the United Kingdom.

One research opportunity arising specifically from this study is an exploration of Millennials' definition, perception and use of humour within the clinical setting, to contrast it with other generational groups. Another would be a longitudinal study incorporating humour and risk, thus determining if students become more risk averse in the use of humour the more senior they become.

In order to expand this researcher's confidence in alternative methodologies, further research can be carried out to explore the current data set using discursive approaches to investigate the identity of a 'good student' through their use of humour.

8.7 Conclusion

To conclude, there are advantages and disadvantages to using humour, but it must be acknowledged humour is part of being human and, if we are to connect with our patients at the most vulnerable points of their lives, we must allow nursing students to learn how to use their own repertoire of humour skills in a safe environment and to grow in their ability to discern when the risk is worth it. Humour remains part of who we are and how we are, and is influenced by where we are, what we want and what situation we are in.

Appendices

Appendix 1: Participant Information Sheet and Consent form

Participant Information sheet

Study: A mixed methods investigation into how pre-registration students negotiate humour in the clinical setting.

You are invited to take part in the above study. Before you decide if you would like to take part in this research, please read the following information and feel free to discuss it with others. The researcher's contact details are at the bottom of this information sheet. Please do not hesitate to make contact with any enquiries you may have.

What is the research about?

The research is gain an insight into how pre-registration students use humour in the clinical setting

Why is the research being undertaken?

This is being undertaken as part of a Professional Doctorate course. Much is written about the use of humour in the clinical setting however the focus remains on registered professionals.

Why have I been chosen?

You have been chosen because you are currently on a pre-registration course at the University of Bedfordshire.

Do I have to take part?

Your participation in the evaluation is entirely voluntary and it is up to you to decide if you wish to take part. Your studies in the university will not be affected in any way if you decide not to take part in the study.

What will happen to me if I take part?

There are two parts to the study:

Questionnaire

This requires you complete an online version of the Humor Style Questionnaire

Interviews:

Semi-structured interviews will be conducted with individual participants willing to discuss their experiences using humour, or lack of, in the clinical setting. This dialogue will be audiotaped, and transcribed in such a way that the research participant cannot be identified

What are the potential benefits or advantages of taking part?

The information you share will allow you to converse with your peers on this topic and establish your style of using humour in an appropriate and professional manner to enhance the quality of care, you offer to patients

Are there any risks or disadvantages of taking part?

There are no risks or disadvantages in taking part of the survey

Can I withdraw from the study?

If you decide to take part you can withdraw from the study at any time without giving a reason. Any data you have already given will be included in the study unless you inform us that you do not wish it to be used.

Will the information I give be kept confidential?

You will not be asked to share any personal details on the questionnaires. All information collected will be treated confidentially and the data will only be reviewed by the research team. The research report, publications and presentations arising from the study will include anonymised data from which no individuals will be identifiable.

Where will the information be kept and who will have access to it?

All the information will be stored in a locked filing cabinet and on password protected university computers. Only the researcher will have access to the information. The information will be kept until the Professional Doctorate has been completed and the necessary reports have been written. The information will then be destroyed confidentially.

What will happen to the results of the research?

The project results will be presented locally within the university and partner NHS Trusts. The project results will also be presented at conferences and submitted for publication in journals for healthcare professionals.

Who is funding the study?

The University of Bedfordshire

Who has approved the study?

The study has been approved by the university's Institute of Health Research Ethics Committee and Cardiff University School of Healthcare Scientific Research Ethics Committee.

What do I do now?

You do not need to do anything now. If you willing to take part, please complete the online questionnaire and provide details if you are willing to partake further

Who can I contact if I have any concerns or questions?

If you have any questions or queries, please feel free to contact me:

Deborah Flynn: Nurse Researcher

Email: deborah.flynn@beds.ac.uk

Telephone: 01582 74 3849

Thank you very much for reading this information sheet

Consent Form for students participating in interviews

Study: A mixed methods investigation into how pre-registration students negotiate humour in the clinical setting.

Please initial

- ☐ I have read the information sheet for the above study and have been given a copy to keep. I have had the opportunity to discuss the details and ask questions
- ☐ The investigators have explained the nature and purpose of the research and I believe that I understand what is being proposed
- ☐ I know that the interview will be digitally recorded
- ☐ I understand that my personal data and involvement in this study will be kept confidential. The research report, publications and presentations arising from the study will include anonymised data from which no individuals will be identifiable
- ☐ I have been informed about how the data will be used and how long it will be kept
- ☐ I understand that I am free to withdraw from the study at any time

Participant's name:

Participant's signature:

Date.....

As the investigator responsible for this study I confirm that I have fully explained the nature and purpose of this study to the participant named above.

Investigator's name:

Investigator's signature:

Date.....

Appendix 2: Cardiff University Ethics Approval

School of Health Care Sciences
Head of School and Dean Professor Sheila Hunt

Ysgol Gwyddorau Gofal Iechyd
Pennaeth yr Ysgol a Deon Yr Athrawes Sheila Hunt



24 January 2014

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Deborah Flynn
1 Sheering Grove
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Dear Deborah

A mixed methods investigation into how pre-registration students negotiate humour in the clinical setting

Thank you for submitting your proposal to the HCARE Research Review and Ethics Screening Committee for:

- scientific review;

The Committee has now had the opportunity to review your proposal, and is happy to approve your plans with the following comment.

- The Committee would suggest that you undertake at least 10 semi-structured interviews plus the questionnaire (rather than the 6-10 as suggested) for this level of work.

Please remember that this Committee (RRESC) is not a research ethics committee (REC), and is therefore not able to give you a favourable ethics opinion. In the view of RRESC your proposal will now need to be submitted for approval to the HCARE REC.

The submission date for the next HCARE REC is 4.00pm on Tuesday 4 February and the research proposal form and accompanying documentation should be emailed to me at Healthcare-Research@cardiff.ac.uk. Details on the format of the research proposal can be found at <http://www.cardiff.ac.uk/sohcs/research/ethics/index.html> including the research proposal application form.

Dates for subsequent meetings are currently being established but it is envisaged that the next meeting may not take place until April at the earliest. Further information will be published when available.

If, in the meantime you have any questions then please do let me know.

Yours sincerely

Liz

Mrs Liz Harmer Griebel
Research, Commercial and Engagement Manager

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School of Health Care Sciences
Head of School and Dean Professor Sheila Hunt

Ysgol Gwyddorau Gofal Iechyd
Pennaeth yr Ysgol a Deon Yr Athrawes Sheila Hunt



Deborah Flynn
1 Sheering Grove
Bradville
MILTON KEYNES
MK13 7BD

12th March 2014

Dear Ms Flynn

A mixed methods investigation into how pre-registration nursing students negotiate humour when working in the clinical setting

At its meeting of 26th February 2014 the School's Research Ethics Committee considered your research proposal. The decision of the Committee is:

Proceed subject to approval of minor amendments by Chair of Committee and one other member.

The following are the amendments/clarification required;

- **General Comments:** This may need ethical approval from Bedford University as well as it is proposed to use nursing students from this institution. A copy of this will need to be provided to the School.

The proposal, amended in the light of the above points, should be emailed to me for consideration by the Committee. When resubmitting your revised proposal you should provide a covering letter highlighting how and where you have amended the revised proposal, in the light of the above comments. You should clearly indicate the page number and line number/s, and you might find the following table a means of reporting the amendments you have made to the proposal.

Comment/Amendment required.	My Response is;	Location in text i.e. page and line number.

Appendix 3: University of Bedfordshire Ethics Approval



14 March 2014

Miss Deborah Flynn

Dear Deborah

Re: IHREC Application No: IHREC336
Project Title: A mixed methods investigation into how pre-registration students negotiate humour in the clinical setting.

The Ethics Committee of the Institute for Health Research has considered your application and has decided that the proposed research project should be approved with no further amendments.

Please note that if it becomes necessary to make any substantive change to the research design, the sampling approach or the data collection methods a further application will be required.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Yannis Pappas'.

Dr Yannis Pappas
Head of PhD School, Institute for Health Research
Chair of Institute for Health Research Ethics Committee

Appendix 4: Extract of humour narratives from Laura

Participant/story	How are they using H in the stories they are telling me	Using McCreddie's (2008b) interpretative framework/Hay's (2001) humour support
Laura- old woman - catheter	Put at ease- reassure- laughed together	Sexual, incongruous. Support: laugh & contribute more humour. Audience: Appreciated and agreed
Laura-older man- suprapubic catheter- women in room	Sexual innuendo- ease the tension as penal bleeding	Sexual, release. Support: contributed more humour. Audience: Appreciated and agreed
Young LD man- rude Makaton sign	Ease his anxiety, family happy she is there, build empathy as has LD son self	Release. Support: laugh Audience: appreciated and agreed
Woman-hairy legs	reassure	Superiority- against self. Support: no data Audience: no data
Dr- catheter-supervised by student	Broke down barriers	Release. Support: no data Audience: no data

Appendix 5: Photograph of theme development



Appendix 6: Steps 3 and 4 of the data analysis: Extracts from Kellie's analysis

Kellie's themes	Quotes
Connectedness:	it's nice to have a bit of a laugh with the nurses or the patients (Kellie 31)
'Get in the bowl'	<p>it's nicer to have that little bit of a joke around before you are doing it, it puts them at ease (Kellie 69-70)</p> <p>then he was a lot more relaxed if you then needed anything done with him then they would ask me to perhaps go and talk to him first so they could get him a bit more calmer before they then went over and done whatever they needed to (Kellie 90-92)</p> <p>I was just joking around with them, just trying to relax them a bit more and not make them feel like they are stuck in hospital which is what they are most of the time (Kellie 111-113)</p> <p>especially my first ever placement and it was the busiest ward I have ever worked on before and there were days where I would hardly see my mentor because we would both be running around and doing stuff but you could still have that joking in between, have a little joke about different things (Kellie 114-117)</p> <p>Like as soon as I came anywhere with them with a needle and stuff like that, they stopped, ha, ha, (Kellie 137)</p>

	<p>mine is normally like light humour (Kellie 199).. ... it would be like a comment on... I don't know, I have had patients say things, like if I say something and they have misheard me then we will have a giggle over that (Kellie 199-201).. and I had a lady who I had turned around to one day and I said 'oh I will just go get the bowl' and she thought I had said 'get in the bowl', like in the M&M advert and that was it, the rest of the shift we were just saying to each other 'get in the bowl' the whole entire shift, ha, ha (Kellie 201-203)</p> <p>dementia patient (Kellie 267)... walked up to this other gentleman's bed and stood there (Kellie 268).. and urinate at the end of this bed and the majority of us all sat there and laughed (Kellie 269).. even the gentleman whose poor bed it was just sat there and laughed (Kellie 270-271)..he seemed to join in though, he was happy and like smiling at us and giggling when we walked him back to his bed to clear him up(Kellie 273)</p>
Appropriateness	<p>[a] dementia patient (Kellie 267)... walked up to this other gentleman's bed and stood there (Kellie 268).. and urinate at the end of this bed and the majority of us all sat there and laughed (Kellie 269).. even the gentleman whose poor bed it was just sat there and laughed (Kellie 270-271)..he seemed to join in though, he was happy and like smiling at us and giggling when we walked him back to his bed to clear him up(Kellie 273)</p>
Tone it down: Recognising the line	<p>it was international nurses day, ha, ha, and we were having a joke around with admin staff (Kellie 166-167)...and she found that sometimes we were being rude to the admin staff (Kellie 169).. it but she was very 'you can't say anything', otherwise that was it, you got in trouble. So if you made a comment like, one of the nurses was saying to one of the admin staff and that was it, she like, she got called into her office to say like 'tone it down a little bit' (Kellie 170-172)</p> <p>mine is normally like light humour (Kellie 199).. ... it would be like a comment on... I don't know, I have had patients say things, like if I say something and they have misheard me then we will have a giggle over that (Kellie 199-201)</p>

I think with friends it's different you do like comment on each other like, laughing at mistakes they have made, but patient wise I won't, like staff members, if they do it to you and you think 'oh I can actually do it to them as well' and we'll all have a little laugh about some of the silly things they have done (Kellie 204-207)

if a patient, if we were in A&E and someone's relative just passed away or someone has just had a very serious traumatic event then you don't really want to use humour at that point, but I think if you have got someone that, say in placement, that has been there two or three months already and getting quite down in themselves, it can help towards providing that compassion and improve the care you are giving them because you're, I don't know, you're treating them in a different way, like trying to raise their spirits a bit more (Kellie 226-231)

I think it can in certain circumstances can be classed as compassionate care because you are showing them that you care about them and you want the best for them and maybe that is just having that little bit of a laugh around to raise their spirits up and give them that little bit of motivation to go 'oh yeah, I might be able to go and do that', whereas some circumstances, that humour was just timed at the wrong point in time then it could make someone feel worse than they actually are (Kellie 233-237)

I think there was a bad experience one day when someone new, when someone said a joke to this patient, I can't for the life of me remember what it was but this patient took it completely the wrong way and thought that this nurse was actually insulting him rather than making a joke about something, so, it was then having to defuse the situation and calm the patient down and say 'actually he didn't mean it that way, but if you want to take it forward then...', gave them all the information, like the staff he needed to contact. (Kellie 259-264)

on my first ever placement I had a full dementia patient who in the middle shift all the nurses, me and some of the nurses were stood around the nursing station, and he walked up to this other gentleman's bed and stood there and proceeded to pull his trousers down and urinate at the end of this bed and the majority of us all sat there and laughed and then carried on with what we were doing and helped clear up the patient and things and even the gentleman whose poor bed it was just sat there and laughed and I think it's hard because obviously the gentleman who had done it wasn't quite with it so didn't really understand why we were all laughing but it was...he seemed to join in though, he was happy and like smiling at us and giggling when we walked him back to his bed to clear him up, so I don't know, it cheered most of the people up in that bay (Kellie 266-274)

it was harsh to laugh because it's obviously not his fault he was doing it but it was one of those moments where you, it's very hard not to, if you understand what I mean (Kellie 275-276)

Impact on patient care

we had a little bit more joke about something to do with water and, erm, I can't remember, it was something to do with tap water not tasting right and tasting like iron and but he calmed down a lot more and just drank the whole entire jug because he didn't need the cannula, so it saved [time & anguish] having to put a needle in him when he didn't necessarily need it straight away (Kellie 86-90)

then he was a lot more relaxed if you then needed anything done with him then they would ask me to perhaps go and talk to him first so they could get him a bit more calmer before they then went over and done whatever they needed to (Kellie 90-92)

I was just joking around with them, just trying to relax them a bit more and not make them feel like they are stuck in hospital which is what they are most of the time (Kellie 111-113)

but I think if you do find it really unprofessional the fact that sometimes you are laughing with a patient and it could influence what, how you treat them and how your practice is done. (Kellie 158-160)

when I have been working with people that don't like to have a joke around I have been a lot more restrained with what I say and I had a shift in placement where someone didn't use that much humour in their life and I was very much more conservative that day and tried to stay away from the two gentlemen I had a laugh around with (Kellie 190-193)

so you don't look too unprofessional to them or, I don't know, you are toning it back a bit more I think, (Kellie 194-195)

..it can help towards providing that compassion and improve the care you are giving them (Kellie 230-231)

it definitely influences the care you give, being allowed to have that, you may not be influencing the patient directly by your sense of humour or humour itself but you are influencing yourself if you can have that little bit of a laugh with a nurse about something and then you are bit more happier to go in and see that next patient (Kellie 245-248)

I do think it affects the way you treat the patients, whether it's directly to them or like humour with nurses or other health care professionals (Kellie 249-250)

<p>Reading the situation: disapproval</p>	<p>there's some nurses that I have encountered don't like, they, I don't know, they don't say it but it's the way they come across, they don't like you having a joke around with the patient or especially in placement, obviously they [patient] are there for quite a long time (Kellie 98-100)</p> <p>but one of the nurses didn't like how close we were getting, she thought I was getting too personal with the patients and stuff like that and when actually I wasn't (Kellie 110-111)</p> <p>I have had some people say I am getting too friendly with someone (Kellie 120)</p> <p>they said it was on placement these two gentlemen, they said I was becoming unprofessional because I was, they said I was becoming too personal with them (Kellie125-126)</p> <p>I do think it influences how you use it, if you have got someone who doesn't want, doesn't like to have a laugh around the patients and stuff like that, you do tend to back off a little bit and laugh about it in your head rather than actually saying it out loud (Kellie 186-188)</p>
<p>Identifying with patient</p>	<p>So two particular gentlemen I have got really friendly with because they are quite, they are the same age as me. (Kellie 104-105)</p>

Suspending reality	I was just joking around with them, just trying to relax them a bit more and not make them feel like they are stuck in hospital which is what they are most of the time (Kellie 111-113)
Can I use? (role model tension)	<p>one of the nurses didn't like how close we were getting, she thought I was getting too personal with the patients and stuff (Kellie 110-111).. whereas other nurses will quite happily joke around with you (Kellie 113-114)</p> <p>so, I don't know, some nurses quite accept having a sense of humour at work, some of them, I think it gets most people through the day in some cases and others they don't like you having that joke around with the patients; they think it's a bit too unprofessional and... like not how your role as a nurse should be. I have had some people say I am getting too friendly with someone. (Kellie 117-120)</p> <p>I don't understand why they said I was becoming unprofessional because as soon as it came to doing anything like washing them or stuff like that I would still do it but I wasn't going to be, like... I don't know, you'd have a joke around with it rather than go 'I am going to do this, I am going to do that' (Kellie 126-129)</p> <p>I think it's different people's views on what's professional and what's not, but I feel that being able to have a joke around with your patients you can still be that professional (Kellie 131-133)</p> <p>I don't know, I think it's different for people's views on what's professional and what's no (Kellie 138)</p>

I think like the nurses that think it's unprofessional, most ones I have known that don't like, like student nurses having a joke around don't really have a joke around themselves, they are very, like other nurses will comment on the fact that you can't have a laugh with them (Kellie 145-148)

a sister on one of the wards I have been on, she is very regimented, she has got folders for absolutely anything and everything. Erm, if she wants something done then it has to be done that way (Kellie 164-165)

I think if I was working with someone who didn't want to have a laugh I think I would be a bit more, I don't know, I think as a student nurse I think I would be a bit more, a lot more, like compliant, and not try and have that joke around, so I do think it does influence you, (Kellie 181-183)

I do think it influences how you use it, if you have got someone who doesn't want, doesn't like to have a laugh around the patients and stuff like that, you do tend to back off a little bit and laugh about it in your head rather than actually saying it out loud (Kellie 186-188)

when I have been working with people that don't like to have a joke around I have been a lot more restrained with what I say and I had a shift in placement where someone didn't use that much humour in their life and I was very much more conservative that day and tried to stay away from the two gentlemen I had a laugh around with (Kellie 190-193)

**Acceptance(hierarchy/
permission to join in)**

..whereas other nurses will quite happily joke around with you (Kellie 113)

..some nurses quite accept having a sense of humour at work (Kellie 117)

I think if I was working with someone who didn't want to have a laugh I think I would be a bit more, I don't know, I think as a student nurse I think I would be a bit more, a lot more, like compliant, and not try and have that joke around, so I do think it does influence you, (Kellie 181-183)

when I have been working with people that don't like to have a joke around I have been a lot more restrained with what I say and I had a shift in placement where someone didn't use that much humour in their life and I was very much more conservative that day and tried to stay away from the two gentlemen I had a laugh around with (Kellie 190-193)

so you don't look too unprofessional to them or, I don't know, you are toning it back a bit more I think, (Kellie 194-195)

like staff members, if they do it to you and you think 'oh I can actually do it to them as well' and we'll all have a little laugh about some of the silly things they have done (Kellie 206-207)

..even the gentleman whose poor bed it was just sat there and laughed and I think it's hard because obviously the gentleman who had done it wasn't quite with it so didn't really understand why we were all laughing but it was...he seemed to join in though, he was happy and like smiling at us and giggling when we walked him back to his bed to clear

	<p>him up (Kellie 270-274)</p> <p>..so it is always nice when you meet them they always put you at ease straight away and most of mine just like introduce themselves and said 'oh I am going to be your mentor' and like, spoken to me about things, but it was just the fact that this woman was different, the fact that I'd didn't even know who she was and I had already seen her belly, ha, ha, so it does relax you a bit more and then you can have that, I don't know, I think it helps with that student and mentor relationship with how you go on in the placement and you are more willing to, because you have to work with your mentor, you are then more willing to work with your mentor (Kellie 308-315)</p>
Power	<p>I don't know what it would be like as a registered nurse but I know as a student nurse, because obviously you are being assessed and stuff like that you don't really want to upset the people you are working with (Kellie 183-185)</p> <p>I don't know, it does help to break the ice [mentor being funny] I think in some situations, especially when you are going to meet someone for the first time, especially someone who is going to be assessing you (Kellie 318-319)</p>
Approachability	<p>it does, but it makes them harder to approach I find, if you have got someone that is not very forthcoming and likes to have a bit of a laugh at work, it's very hard to then go up to them and then ask them for something or to do something for you (Kellie 173-175)</p> <p>like staff members, if they do it to you and you think 'oh I can actually do it to them as well' and we'll all have a little laugh about some of the silly things they have done (Kellie 206-207)</p>

Mentor relationship

especially my first ever placement and it was the busiest ward I have ever worked on before and there were days where I would hardly see my mentor because we would both be running around and doing stuff but you could still have that joking in between, have a little joke about different things (Kellie 114-117)

I enjoyed my community, my mentor was pregnant and we used to giggle about tons of stuff she used to do; the fact that she was always eating, I hardly ever saw her without something in her hand and the first time I ever met her was when she walked into a room, lifted up her tunic and someone asked me, someone shouted 'show me your belly' and that was how I met her, ha, ha, erm, it was a good start to the mentor–student relationship we had. (Kellie 296-301)

when you go to a placement first off and all you are told over the phone or by a letter is your mentor is so and so and you then have visions in your head of this really, really strict nurse that is not going to let you do anything wrong and I know that's just a view most of us have, the fact that you are going to be the worst person ever, so it is always nice when you meet them they always put you at ease straight away and most of mine just like introduce themselves and said 'oh I am going to be your mentor' and like, spoken to me about things, but it was just the fact that this woman was different, the fact that I'd didn't even know who she was and I had already seen her belly, ha, ha, so it does relax you a bit more and then you can have (Kellie 305-312)

I think it helps with that student and mentor relationship with how you go on in the placement and you are more willing to, because you have to work with your mentor, you are then more willing to work with your mentor whereas other placements you are a bit more reluctant to go in and work with your mentor some days, and yeah, it does put you at ease when they come in and do something ridiculous like that, ha, ha. (Kellie 313-317)

Definition	<p>something or something that someone has done or someone has said that you can have a little giggle or gives you a little bit of a smile (Kellie 217-218)</p> <p>it's very hard to define (Kellie 218)</p> <p>It gives you that little smile on your face (Kellie 219)</p> <p>it is very hard to define because everyone has their own ideas of what is humorous and what isn't. I don't know, anything that gives someone a smile on their face at the end of whatever happens. (Kellie 220-222)</p>
Reconciling acuity of placement with humour use	<p>well, most of my placements have been acute, so that doesn't help, but being able to put people's minds at rest I think helps by having that little bit of humour, you can have a giggle around with them about stuff that they have said to you or something like that. (Kellie 210-212)</p>
Compassion	<p>..but in my sight, being able to relax your patients with that little bit of humour helps rather than just going and doing the job and walking away again. (Kellie 138-140)</p> <p>laughing at mistakes they have made, but patient wise I won't (Kellie 205-205)</p>

	<p>I think you can in some situations (Kellie226)</p> <p>I think if you have got someone that, say in placement, that has been there two or three months already and getting quite down in themselves, it can help towards providing that compassion and improve the care you are giving them because you're, I don't know, you're treating them in a different way, like trying to raise their spirits a bit more (Kellie 228-230)</p> <p>I think it can in certain circumstances can be classed as compassionate care because you are showing them that you care about them and you want the best for them and maybe that is just having that little bit of a laugh around to raise their spirits up and give them that little bit of motivation to go 'oh yeah, I might be able to go and do that', whereas some circumstances, that humour was just timed at the wrong point in time then it could make someone feel worse than they actually are (Kellie 233-237)</p> <p>So, I think it can form part of compassionate care. I think most people use a little bit of humour in their life to get through as a nurse (Kellie 240-241)</p>
Quality of learning	I think it helps with that student and mentor relationship with how you go on in the placement and you are more willing to, because you have to work with your mentor, you are then more willing to work with your mentor whereas other placements you are a bit more reluctant to go in and work with your mentor some days (Kellie 313-316)
Hardness of placements	like some of the placements I have been on have been quite acute wards (Kellie 26)
Busyness (good & bad)	..nurses are running around like headless lunatics, you can have a little bit of a joke and they relax a bit more and, I don't

know, it helps get through the day as well, when you are having a hard day it's nice to have a bit of a laugh with the nurses or the patients. (Kellie 29-30)

and it was the busiest ward I have ever worked on before and there were day(Kellie 113)

**Situational effects of shift
on student**

had my first ever cardiac arrest so I was a bit down in the dumps about that (Kellie 35-36)

Linguistic comments

Kellie used the word 'I don't know' 53 times during this interview. Discourse markers (Laserna et al 2014).

Conversation fillers – um, err, have 2 purposes: either to give interviewee time to think or show's their attitude – so there could be a level of uncertainty with Kellie's

Mentions 8 times the need for humour in order to stay or keep going – demonstrates hardness of journey; 35–39; 43; 71–73; 241; 244; I 264–266; 283)

Use of I vs we (us#)

Reflexivity

Expected more from Kellie due to seniority in programme and being a caremaker (NHS)

Used expanding & probing numerous times

Trying to be reassuring (62)

Definite emic moments: (226; 243 – laughing together; 276)

I was judgemental (94)

One question was too many variables (94-96; 214–215)

Missed opportunity to go into depth (178) could have asked if this applied to learning opportunities

Several terms of language denote the familiarity between the interviewer and interviewee within the 'world reality': unfinished sentences (pre-existing knowledge assumption); imprecise references (shared knowledge); fillers – needs to work out what she wanted to say; long pauses and voiced hesitations allows the participant to keep control of the interview; use of contractions as participant wanted to get things s

Step 4: Kellie's themes		
Connectedness: 'Get in the bowl'	Compassion	"They are people you know": being human
Appropriateness	"They are people you know": being human	
"Tone it down": Recognising the line	Identifying with patient	
Consequences	Suspending reality	
Headless lunatic: Chaos (un- thinking behaviour) (Hardship of placements con- trasted to regimented)	Customer care (Being more receptive)	
Easing situations	Being the catalyst	
Survival	"Tone it down": Recognising the line	"Tone it down": Recognising the line
Types of humour used (Ob- servational/situational)	Consequences	
Allowed (or not) to make mis- takes	Appropriateness	
Dark humour	Connectedness: 'Get in the bowl'	Connectedness: 'Get in the bowl'
Hesitation to blame	Easing situations	
Influences	Taking the time: shared mo- ments	Taking the time: shared mo- ments
Customer care (Being more receptive)	Survival	Survival
Being the catalyst	Coping	
Taking the time: shared mo- ments	Reconciling acuity of place- ment with humour use	
Impact on patient care	Hardness of placements	
Reading the situation: disap- proval	Busyness (good & bad)	

Identifying with patient	Situational effects of shift on student	
Suspending reality	Journey	Journey
Can I use? (role model tension)	Influences	“It[humour] affects the way you treat the patients”: influences & impact
Acceptance(hierarchy/permission to join in)	Impact on patient care	
Power	Can I use? (role model tension)	Can I use?: Role model tension
Approachability	Acceptance(hierarchy/permission to join in)	
Mentor relationship	Regimented	
Regimented	Reading the situation: disapproval	
they are people at the end of the day: humanity	“Headless lunatic”: Chaos	“Show me your belly”: student–mentor relationship
Coping	Mentor relationship	
Journey	Approachability	
Definition	Power	
Reconciling acuity of placement with humour use	Quality of learning	
Compassion	Allowed (or not) to make mistakes	
Quality of learning	Types of humour used (Observational/situational)	Definition and types
Hardness of placements	Definition	
Busyness (good & bad)	Dark humour	Dark humour
Situational effects of shift on student	Hesitation to blame	

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